Medicaid: 1973–1979

A Selected Annotated Bibliography

U.S. Department of Health, Education, and Welfare
Health Care Financing Administration

Progress Through Partnership
Medicaid Medicare Management Institute

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December, 1979

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INTRODUCTION

This is the second bibliography of literature related to Medicaid operations and management. It updates an earlier publication, The First Six Years of Medicaid, A Selected Annotated Bibliography, published in 1972. The period 1973-1979 is covered in this bibliography.

The Medicaid program has shown substantial growth from 1973 to 1979. In 1978, an estimated 22 million people received medical assistance through the Medicaid program, at a cost of $18 billion. This compares to a 1973 estimate of 18 million recipients at a cost of $9 billion.

This bibliography is divided into twelve sections, as shown in the Table of Contents. An appendix includes additional information related to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) prepared by the Office of Child Health.

With the exception of the items listed in the appendix, the M/MMI does not maintain copies of the materials listed in this bibliography. Readers may obtain the material from a library or by contacting the sources shown for each item.

SECTION I

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

1. U.S., Department of Health, Education, and Welfare. Health Care Financing Administration. Guide to Administration, Diagnosis, and Treatment for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) Under Medicaid, by G. Hass and M. Scovell. Washington, DC: 1977.

Guidelines to aid in the provision of health care under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program under Medicaid are presented. The need for EPSDT is discussed, with emphasis on special problems in the diagnosis and treatment of Medicaid-eligible children and child abuse and neglect. Community resources that may aid in the implementation of the EPSDT program are discussed. Consideration is given to the expansion of limited resources and the identification and organization of resources, school health programs, State health agencies, Head Start, private physicians, hospitals, referrals, neighborhood health centers, health maintenance organizations, and dental services. The following aspects of service organization are addressed: responsibility for care, program initiation, outreach, outreach workers and health aids, media, use of the Aid to Families with Dependent Children system, transportation, referral management, records and forms, terminology, manuals, and medical advisory committees. The cost and evaluation of an EPSDT program are also explored. Particular attention is given to budgeting, cost efficiency, and audit. Health supervision, preventive services, and periodicity are discussed, as well as problem management for history and physical examinations, immunizations, dental care, vision, hearing, growth and nutrition development, tuberculin sensitivity, bacteriuria, anemia, sickle cell disease, and increased lead absorption. Additional information on the EPSDT program is appended.

2. U.S., Department of Health, Education, and Welfare. Health Care Financing Administration. Overview of the Medicaid Early and Periodic Screening Diagnosis and Treatment Program, by R. Manela and others. Washington, DC: 1977.

An overview of the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is presented. EPSDT program services are intended to identify any physical and/or developmental problems of children and youth eligible for the Aid to Families with Dependent Children program and some other low-income families and to assure the provision of necessary follow-up treatment. Requiring States to insure that periodic screening, diagnosis, and treatment are furnished for eligible children and youth helps assure them of adequate preventive as well as remedial health care services. The Federal government provides matching funds to States for implementing an EPSDT program. In each State, a specific agency is responsible for EPSDT. State responsibilities in conducting the program are delineated and concepts embodied in the EPSDT program are discussed. Early detection and treatment can maximize the chance of effective treatment and minimize the effects of health problems. Periodic screening provides a way of checking on the growth and development of a child and allows trained health workers to detect health problems. Screening is the use of quick tests and

brief procedures to detect the early stages of physical and developmental problems. Diagnosis involves ascertaining the nature of a health problem so that specific treatment can be planned. Treatment is the key to a successful EPSDT program. An inventory of common EPSDT screening procedures is included.

3. Children's Defense Fund. EPSDT: Does it Spell Health Care for Poor Children? Washington, DC: Children's Defense Fund, 1977.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), an amendment to Title XIX of the Social Security Act which requires those States with Medicaid programs to provide Medicaid-eligible children with EPSDT services, is explained and evaluated. EPSDT ensures not only that reimbursement is provided but that periodic screening, diagnosis, and treatment is available to the clients. The opening material explains the major features of Medicaid and EPSDT. Topics subsequently examined include deficiencies in the administration and enforcement of EPSDT; the issue of whether the program is really reaching the children it is intended to serve; and the results of assessments of both the screening and the diagnosis and treatment aspects of the program. Among the study findings are that the individual-oriented parts of the screening package, such as health histories and reviews of growth and development, were not as well done as other parts, and further, that they were done less frequently. The findings also indicate that many of the children had not received the diagnosis and treatment they needed. The study also examined the developmental needs of the children, including the reasons why it is so important to attend to these needs and how developmental assessment is working in EPSDT; and EPSDT's potential and performance as it relates to linking children to ongoing primary health care. Recommendations accompany the text. The appendixes provide additional information on the study procedures and samples, EPSDT lawsuits, and single State Medicaid agencies and EPSDT coordinators. In addition, national EPSDT data and a selected bibliography are included.

4. U.S., partment of Health, Education, and Welfare. Health Care Financing Administration. Assessment of EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) Practices and Costs. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

The primary objectives of the assessment were (1) to determine whether screening and case management methods affected types of conditions uncovered, validity of findings, cost, capacity of the system, rates of treatment completion, and subsequent participation of recipients in comprehensive care programs, and (2) to find the most efficient and effective approaches to screening and case management. The Best Practices Report reviews the EPSDT practices of only 18 localities in the six State sample. The report does not present a review of all types of providers or practices. None of the six States visited was located west of the Mississippi River. This report describes and analyzes the best practice components of the EPSDT program and assesses the impact of several specific variables on the EPSDT system.

5. Miller, John C. "How Texas Makes EPSDT Work -- Aggressive Outreach and Follow-Up Efforts Are Keys to Effective State Program." HCFA Forum, 2/1 (1978): 10-13.

The provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in Texas is detailed. At any given time, there are an estimated 250,000 children in the State eligible for EPSDT. The dental examination plan in Texas calls for examinations every 3 years; in actual practice, medical and dental examinations are given annually if requested. Texas has divided its EPSDT functions between the Department of Human Resources and the Department of Health. There are 485 examination sites in the State, many of which are served by 16 medical teams and four dental teams. Converted recreational vans serve as mobile dental offices. Twenty-five percent of EPSDT funds are allocated to finding eligible children for the program and guiding them through the program. A sophisticated case management process has been developed. Examinations are performed by registered nurses who present their findings to a physician for evaluation. Even if a child has no apparent dental problems, he or she is referred to a dentist if a checkup has not been performed within a year. Medical examinations are reimbursed through the State's health insurance contract. Reimbursement for treatment is based on customary and reasonable fees established for the Medicaid program. The success of the EPSDT program in Texas is discussed.

6. Currier, Richard. "Is Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Worthwhile?" Public Health Reports, 92/6 (1977): 527-536.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) programs in Sweden and the State of Michigan are described. Screening, as practiced in EPSDT programs, includes a health history, physical assessment, check on immunization status, and tests. This type of screening is considered to be an efficient and effective way of providing health care to children in low-income families. An amendment to Title XIX of the Social Security Act requires States to provide EPSDT for all Medicaid-eligible persons under 21 years of age. In Sweden's EPSDT program, free and voluntary multiphasic screening is provided to all children 4 years of age. The Michigan EPSDT program is the responsibility of the Department of Social Services and was initiated in 1973. As of October 1976, 425,000 persons had been screened, representing 10 percent of all Medicaid screening in the United States. Variables affecting the outcomes of persons screened in Michigan are noted, and supporting data are provided. Studies conducted to evaluate the efficacy of EPSDT are cited.

7. Brooks, Charles H. "Infant Mortality in SMSAs Before Medicaid -- Test of a Causal Model." Hospital Research and Educational Trust, 13/1 (1978): 3-15.

This study's goal is to prove that medical resources mediated the effects of racial composition and low income on infant mortality in

standard metropolitan statistical areas (SMSA's) before the advent of Medicaid. Path analysis was applied to 1961-1965 data on infant mortality, the supply of physicians and hospital beds, and population percentages of blacks and low-income families in 210 SMSA's. A structure equation model was used in data analysis. The results show that the availability of medical resources to residents of SMSA's is not a strong mediating factor in correlations between population characteristics and infant mortality rates. This conclusion is based on the following observations: (1) direct effects of the percentage of blacks in the population on neonatal and postneonatal deaths were substantially larger than corresponding direct effects of obstetricians, gynecologists, pediatricians, non-Federal physicians, and hospital beds per 1,000 population; and (2) indirect effects of low-income and percentage of blacks that occurred through the above measures of resource availability accounted for a minimal percentage of their total associations with neonatal and postneonatal deaths. The use of SMSA data for analysis is contrasted with the use of county data in a discussion of another study. Equations and tables of information pertinent to the study are included.

8. Moore, Beatrice D. "Implementing the Developmental Assessment Component of the EPSDT Program." American Journal of Orthopsychiatry, 48/1 (1977): 22-32.

The process of developmental review plays an important role in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) programs. Review has three goals, according to the American Association of Psychiatric Services for Children (AAPSC): (1) the promotion of the strengths of the child and family to cope with the various tasks of living; (2) the prevention of specific developmental disabilities; and (3) early case finding. Adequate review encompasses biological, psychological, family, environmental, social, and cultural dimensions. It should be conducted in three stages: biological review by the pediatrician; direct observation of the child's functioning; and detailed analysis of interrelated individual and environmental factors. Emphasis has shifted from detection of dysfunction to protection of child development. Collaboration between AAPSC and EPSDT has been established on standards development, evaluation of tools and materials, and program review procedures. Confidentiality and legal issues will also be considered. Criteria for review of child health programs include acceptability to all involved, reliability, accuracy in problem identification, cost effectiveness, and ready availability. Parents must play a vital role in assessment and treatment of their children. Through effective review, EPSDT programs can offer critical services to America's disadvantaged children. A six-item bibliography is provided.

9. Community Health Foundation, et al. Head Start and Early and Periodic Screening, Diagnosis and Treatment -- Recipes for Success. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Developed for individuals working with the health component of Head Start, the manual is intended to aid effective utilization of the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. It does this by (1) providing Head Start health coordinators with a better understanding of the EPSDT program, and (2) sharing the knowledge of 200 Head Start EPSDT demonstration projects. The first section is a history: a summary of government health care programs for children prior to EPSDT, an overview of EPSDT, difficulties encountered in implementing this preventive health care program for children, and a summary of the initial Head Start-EPSDT programs. The second section contains recipes to help in implementing separate components of the Head Start-EPSDT program, based on material generated by the centers. Areas of advice covered are collaboration of State and local health and welfare agencies, collaboration with local providers, outreach, transportation, referral and follow-up, record-keeping, and reimbursement. A model of a small community Head Start-EPSDT program is given.

10. "EPSDT in Practice: What's Happening in the Field?" American Journal of Orthopsychiatry, 48/1 (1978): 77-95.

A study of five local program operations in different States around the country indicates that EPSDT is presently ineffective in identifying, referring, and treating children with developmental difficulties. It is suggested that problems in implementation are not merely administrative, and that developmental screening may best be carried out within the context of routine, comprehensive pediatric assessment.

11. "Developmental Assessment in EPSDT: the American Orthopsychiatric Association." American Journal of Orthopsychiatry, 48/1 (1978): 7-21.

This study, initially aimed at preparation of a guide for State and local administrators and service providers responsible for EPSDT developmental assessment and treatment, concludes that EPSDT, as currently constituted, cannot adequately meet the urgent developmental needs of the poor children it is meant to serve. Professional and administrative limitations of the program are outlined, and pilot studies to seek sound solutions are suggested.

12. Stringer, L. A. "Mental Health Work in Children's Health Centers: Learnings from Five Years' Experience." American Journal of Orthopsychiatry, 48/1 (1978): 40-55.

A five-year-old program of an EPSDT-kind is examined with respect to 1) its potential for prevention of disabling conditions, and 2) the kinds of problems encountered and solutions attempted. Two glaring needs appear -- for stronger support systems, and for more relevant training in outreach work.

SECTION II

Eligibility

1. Spitz, Bruce and Holahan, John. Modifying Medicaid Eligibility and Benefits. Washington, DC: The Urban Institute, 1977.

Eligibility options and problems confronting an individual State Medicaid program are addressed, and the implications of altering benefit packages are examined. State choices with respect to placing limitations on eligibility are considered, including eligibility requirements mandated by Federal regulations. It is concluded that State programs will not solve fiscal problems related to Medicaid through either the manipulation of eligibility criteria or increased quality control efforts. Reducing the number of ineligibles and the amount of client fraud has considerably more political appeal. Options available to States for reducing Medicaid costs through limitations on benefit packages are discussed. Although the Federal Government requires that all Medicaid programs offer a basic benefit package comprised of mandatory services, optional services may be offered at the discretion of States. The measure most frequently employed by States to control Medicaid program costs is the elimination of, or limitations on, optional covered benefits. It is argued that, in general, this measure is not an effective cost containment strategy.

2. U.S., Department of Health, Education, and Welfare. Social and Rehabilitation Service (now Health Care Financing Administration) and Urban Systems Research and Engineering. Executive Summary and Overall Evaluation of Medicaid Spend-Down. Vol. 1. Evaluation of Medicaid Spend-Down. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Spend-down is a part of the medically needy program directed at extending medical assistance coverage beyond those who are normally included. It is based on the provision of the Medicaid law which stipulates that in computing a family's income there shall be excluded any cost (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law. The specific objectives of the study have been: to analyze the implementation and administration of the spend-down program among several States, to determine various characteristics (socio-demographic, economic, behavioral, and health care utilization) of successful and unsuccessful spend-down applicants compared to other Medicaid populations, and to estimate the spend-down participation rate, i.e., the extent to which the potentially eligible spend-down population is actually enrolled in Medicaid.

3. U.S., Department of Health, Education, and Welfare. Health Care Financing Administration, and Urban Systems Research and Engineering. Comprehensive Review of Medicaid Eligibility, by Marilyn Rymer, et al. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

Many problems currently exist in the structure and functioning of Medicaid eligibility, primarily because the law and the regulations are a confusing mass of mandatory and optional coverage groups, exceptions provisions, grandfather clauses and hold harmless requirements. This report provides comprehensive documentation of current problems in Medicaid eligibility and analyzes alternative directions and degrees of reform. In carrying out the project, the contractor reviewed the administration of the Medicaid eligibility system in nine States (including 18 local offices), held discussions with Federal, State and local personnel, and reviewed existing literature relevant to problems of inequities and disincentives in current eligibility policy and practice. The contractor then specified five alternative approaches to reforming Medicaid eligibility and analyzed each alternative for its administrative feasability and its impact on equity and incentive considerations. The alternatives considered stopped short of national health insurance. The final report details the equity, incentive and administrative problems uncovered and presents the analysis of alternatives.

4. U.S., Department of Health, Education, and Welfare. Social and Rehabilitation Service, and Applied Management Sciences. State Medicaid Tabulations, Appendix A. A Ten State Study of Medicaid Eligibility and Utilization Changes Coinciding with the Introduction of the Supplemental Security Income Program. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Data on Medicaid programs in ten States are tabulated in an appendix to a survey report concerned with Medicaid eligibility and utilization changes coinciding with introduction of the Supplemental Security Income (SSI) program in January 1974. Data were obtained from computerized files on Medicaid eligibility and Medicaid claims in ten States for 1973 and 1974. It was necessary to examine a portion of 1975's paid claims as well to identify those paid for services received in 1974. Tabulations on data for long term care services are provided which cover long term hospitals, home health services, skilled nursing facilities, and intermediate care facilities. Utilization, expenditure, and recipient data are included for comparison with data on the eligible Medicaid population. Medicaid program data from the following States are presented: Oklahoma, Mississippi, New Mexico, North Dakota, Tennessee, Alabama, South Carolina, Kentucky, Michigan, and Washington. Portions of this document are not fully legible.

SECTION III

Quality Assurance and Control

1. Jonas, Steven. Quality Control of Ambulatory Care: A Task for Health Departments. New York: Springer Publishing Co., 1977.

Some of the problems related to the provision of quality ambulatory care by health departments are addressed in this book. Ambulatory care is noted as the most prevalent form of health service delivery in the United States. The impact of national health insurance on ambulatory care is assessed. Examples of government-funded ambulatory care programs in New York State as prototypes of how the government can provide subsidies and at the same time control expenses and quality are examined. Hospital ambulatory services and health care quality measurement and control are discussed. Legislative developments in New York that affect ambulatory care are traced, with particular reference to public health laws. The concept of 'ghetto medicine' is addressed, along with the ambulatory care program in New York City as of 1975. Lessons learned from the experience of New York State in funding ambulatory care programs are analyzed and their implications for national health insurance are considered. Twelve appendices provide further information on public health and ambulatory care in New York State. An index is included.

2. Cappelli, A. P., and Stralberg, H. Impact of Utilization Controls on Medicaid -- Phase II. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

In response to Federal legislation, States have adopted a variety of utilization control (UC) methods to improve the management of Medicaid by emphasizing accountability while maintaining necessary care. This paper offers an in-depth study of UC impact in Michigan, Virginia, and California, and develops a general methodology to measure UC effectiveness in other States. UC refers to procedures for review and certification of the necessity, appropriateness, and quality of institutional care provided Medicaid patients. Three State-administered review procedures are considered: (1) preadmission review, aimed at avoiding unnecessary admission; (2) periodic concurrent review, to determine the medical necessity of continued stay; and (3) on-site medical review (MR) and independent professional review (IPR), aimed at assuring the quality and appropriateness of long term care. Major conclusions which emerged from the analysis included: all of the State review methods appear to be cost effective; UC has been associated with significant changes in institutional utilization patterns (generally in the direction of less expensive modes of care); and declining denial rates indicate that UC is an ongoing deterrent to unnecessary utilization. Net Medicaid cost savings estimates varied from 2.5 percent in Virginia to 14 percent in California. Changes in utilization were toward fewer admissions, reduced lengths of stay, and shifts from higher to lower levels of care. However, reduced utilization rates were not inconsistent with quality-of-care requirements. Insights were also gained into external factors influencing UC effectiveness. Numerous tables and figures accompany the study, as well as appended material on data collection and analysis techniques. Two pages of references are also provided.

3. Holahan, John, and Stuart, Bruce. Controlling Medicaid Utilization Patterns. Washington, DC: The Urban Institute, 1977.

Cost sharing and utilization control aspects of the Medicaid program are evaluated. Arguments for and against cost sharing as a cost control device available to States are presented. It is noted that States are permitted to use cost sharing, defined as the payment by the recipient of some portion of the bill for a service at time of use, as a cost control device. This use of cost sharing, however, is limited to nominal co-payments on optional services for cash assistance recipients and on all services for the medically needy. The most common rationale for the use of cost sharing is that it will introduce cost consciousness on the part of recipients and discourage the use of unnecessary services and excessive drug prescriptions. Although evidence on the efficiency of cost sharing is not definitive, it is suggested that cost sharing can be a fairly equitable approach to reducing Medicaid program costs when compared to other forms of control, such as the elimination of services and limits on hospital days, if imposed primarily on routine services. Utilization control strategies are discussed, with utilization control defined as any regulatory mechanism which materially affects the behavior of providers and/or patients in terms of the quantity, quality, or type of medical service utilized. Limitations on and the potential for cost containment through utilization control are examined. Three requirements for effective utilization control are identified: appropriate targeting, enforceability, and efficient administration. Particular attention is given to the classification of utilization control mechanisms as predelivery controls, concurrent review, or post-treatment review.

4. Chao, Cedric C. "Cost and Quality Control in the Medicare/Medicaid Program -- Concurrent Review." Harvard Civil Rights - Civil Liberties Law Review, 11/3 (1976), 664-700.

The effectiveness of concurrent review as a means of preventing the improper utilization of medical resources under the Medicare and Medicaid programs is evaluated. Possible policy objections to concurrent review which must be addressed by persons seeking to reduce costs and improve the quality of health services are noted. Major problems faced by Medicare and Medicaid are identified as rising costs and uneven quality of care. The achievement of government objectives through concurrent review is assessed. Certain structural and conceptual difficulties inherent in concurrent review are discussed. The statutory objection that utilization review violates the Social Security Act by interfering with the physician's practice of medicine and by mandating a treatment process not in the patient's best interests is examined. The argument that concurrent review intrudes upon a constitutionally protected right to privacy by affecting the patient's decisionmaking processes and by adversely affecting the physician-patient relationship is analyzed. It is concluded that statutory and constitutional objections to concurrent review can be overcome, but that it may be difficult to determine the effectiveness of concurrent review in achieving its defined objectives. It is recommended that a flexible approach to concurrent review and alternative utilization control techniques be adopted in order to meet the objective of high quality health care at a reasonable cost.

5. Donabedian, Avedis. "Quality of Medical Care." Science, 200/4344 (1978): 856-864.

As a result of many perceived deficiencies in the quality of medical care administered in the United States, the Congress included as part of the 1972 amendments of the Social Security Act a provision to establish local Professional Standards Review Organizations (PSRO's) within each State to monitor the quality of care. At first, these PSRO's are to be concerned only with the quality of care given in hospitals and nursing homes that are to be paid through Medicare and Medicaid. Later, however, ambulatory services are to be included. The PSRO's have been opposed by most groups that must work with them, including physicians, nurses, and consumers. Present conditions in the administration of medical care, however, clearly require some more overt type of action in appraising the care that is given. The present methods of evaluation rely on the personnel and physical structures of the facility, or on tracing the progress of one type of disease, or on the outcome of sampled cases. All methods, however, show shortcomings. Many examples are cited. In one Baltimore study, great variation was found in the percentages of diseased and nondiseased appendixes removed, depending on how the hospital was to be paid. For welfare patients, 40 percent of the appendixes removed were not diseased. For those who paid their own hospital bills, the figure was 42 percent. For those who had insurance other than Blue Cross and for those who had Blue Cross, the figures were 50 percent and 55 percent, respectively.

6. Jessee, William F.; Ford, Leslie G.; and Tebbutt, Jane S. "Implications of PSRO's for Long Term Care." Hospitals, 50/15 (1976): 140.

The role of Professional Standards Review Organizations (PSRO's) in long term care is explored. PSRO's have the responsibility for reviewing health care services provided by or in institutions under the Medicare and Medicaid programs in order to insure that such services are medically necessary, appropriate, and of high quality. The expansion of the PSRO program to encompass long term care facilities is discussed. Long term care facilities include both skilled nursing and intermediate care facilities. It is pointed out that fiscal restraints have limited the expansion of PSRO's in the long term care field. The involvement of Federal health care financing programs in long term care is noted. Methods used to evaluate the quality and necessity of care in long term care facilities are examined. PSRO considerations in long term care are detailed, and a model long term care review system is presented. Problems associated with implementing PSRO concepts in the long term care review system are delineated.

SECTION IV

Health Plans

PREPAID PLANS:

1. Fuller, Norman A.; Patera, Margaret W.; and Koziol, Krista. "Medicaid Utilization of Services in a Prepaid Group Practice Health Plan." Medical Care, 15/9 (1977): 705-737.

Medical care utilization was compared for a group of 834 individuals in the District of Columbia 22 months before enrollment in a prepaid group practice and 22 months after enrollment. To provide medical services at lower cost without diminishing either quality or coverage, approximately 1,000 Medicaid beneficiaries voluntarily enrolled in a prepaid group practice. The benefit package provided by the prepaid group practice to its Medicaid enrollees included complete ambulatory care, inpatient care, skilled nursing home care, short term psychiatric care, laboratory services, optical services (including eyeglasses), drugs (prescription and over-the-counter), podiatry, physical therapy, dental care, and ambulance service. Ambulatory physician encounter rates decreased by 15 percent, drug utilization was down 18 percent, hospital admissions decreased by 30 percent, and hospital days declined by 32 percent after enrollment. Annual prepaid per capita costs for the Medicaid prepaid group practice enrollees represented a 37 percent savings when compared to fee-for-service per capita costs of the Medicaid universe. The study group was satisfied with the prepaid group practice and received better dental care. The voluntary dropout rate from the prepaid group practice was only 2.5 percent and out-of-plan utilization was low. The findings suggest that substantial cost savings may be possible if large numbers of Title XIX eligibles are given an opportunity to enroll in prepaid group practices. Supporting tabular data are provided.

2. Bossh, Samuel J., et al. A Prepaid Health System for Medicaid Eligible Children and Their Families. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

The report describes the structure and functioning of a model prepaid health plan designed to facilitate the access of Medicaid-eligible inner-city families to already available health services. The model is community-based and is designed to address problems of accessibility, equity, accountability, continuity of care and consumer participation. In essence, the model system, operating through the schools in a geographically defined area, proposes to use existing funds to assure a linkage between families in need of care and providers already operating in the area through a modification of the usual method of allocating Medicaid monies. Inspired by the Kaiser-Permanente system, its most salient characteristics are: (1) use of the schools as an organizational focus for development of a health plan in inner cities, (2) an administrative structure responsible for establishing and maintaining functional linkages among funding agencies, existing health care providers and consumers, and (3) prepayment of Medicaid services through capitation.

CAPITATION PLANS:

1. Johnson, Norman C., et al. Iowa Title XIX Experimental Capitation Program for Pharmaceutical Services. Springfield, VA: National Technical Information Service, U.S. Dept. of Commerce, 1977.

This project was designed to modify one component of the Medicaid program in Iowa, the drug program, in an attempt to improve efficiency. Background information on inadequacies of the Medicaid drug program is presented. These inadequacies concern professional fees, reimbursement, administrative problems, consumer aspects, and financing. In 1972, it became apparent that the Iowa Medicaid drug program needed to be modified in order to enhance its efficiency and quality. The experimental project incorporated capitation reimbursement, as well as other techniques, and involved a contractual relationship between the Iowa State Department of Social Services and pharmacies in two counties responsible for the provision of drug services to Medicaid patients. The aspects of the project which are examined include the roles and responsibilities of patients, pharmacists, physicians, the Iowa State Department of Social Services, and Blue Cross of Iowa, and evaluation (the drug use process, services, consumer acceptance, and pharmacy costs and acceptance). The project findings are not detailed in the report, although the potential value of the project is discussed in relation to national health insurance.

HEALTH MAINTENANCE ORGANIZATIONS:

1. Rabin, David L.; Bush, Patricia J; and Fuller, Norman A. "Drug Prescription Rates Before and After Enrollment of a Medicaid Population in an HMO." Public Health Reports, 93/1 (1978), 16-23.

A project was conducted from 1971 to 1974 to evaluate drug utilization rates for Medicaid recipients enrolled in a health maintenance organization (HMO) in Washington, DC. In addition, a comparison was made between the Medicaid group in the HMO and the entire pool of Medicaid recipients in Washington, DC. About 4,000 letters were sent to heads of Medicaid households living in the service area of the HMO inviting them to enroll. In addition to the continued availability of the full range of Title XIX benefits, two special benefits were offered as inducements to volunteer for the project (waiver of eligibility redetermination for the 3 years of the project, and free dental care). The use of health services and drugs by the study group of 781 persons was observed at six intervals: 12, 18, and 22 months; three times at these intervals before enrollment in the HMO, and three times after enrollment. Comparisons of the study and control groups are reported in five areas: rates of use of prescription drugs by age and eligibility status; physician visit rates; costs of drugs; rates of use of prescription drugs by therapeutic category and by specific drug; and prescribing quality. The results indicate that the enrollment of a Medicaid population in a prepaid health plan may decrease the use of prescribed drugs and costs, with no apparent diminution in quality and with high enrollee satisfaction. Supporting data are provided.

2. "Concept of Prepaid Health Care Attracts Attention on Wide Scale." Review, 7/4 (1978): 13-17.

The health maintenance organization (HMO) concept of prepaid group health care is evaluated. Statistics on HMO membership and operations are presented, and adverse criticism of HMO's is noted. Criticism stemmed from the Senate Permanent Investigations Subcommittee's report on the California Prepaid Health Plan (PHP), which alleged that PHP was mismanaged over a period of years while DHEW failed to respond in a timely way to

information it received on fraud and abuse. Congressional concern about what happened in California resulted in a number of restrictions and monitoring mechanisms being introduced into the 1973 HMO Act. In 1976, Congress further amended the HMO Act to insure that Medicaid prepaid risk contracts were subject to Federal regulation. The 1978 amendments are directed at financial disclosure of parties and interests on HMO boards that also relate to corporations with which the HMO does business. Considerable evidence exists to indicate that HMO capitation systems can result in lower costs, fewer cases of elective surgery, and lower hospitalization rates. The expansion of HMO's requires a large-scale restructuring of the nation's health care delivery system. Public policy has discriminated against HMO's and favored fee-for-service practice.

SECTION V

Long Term Care

1. Samuelson, Robert J. "Busting the U.S. Budget -- The Costs of an Aging America." National Journal, 10/7 (1978): 256-260.

Federal programs that involve expenditures for the elderly population are examined. It is envisioned that the growth in the elderly population will centralize more spending and power in the Federal government and that State and local government spending will decrease. Costs in maintaining the elderly are the concern of both industry and government; in industry, the focus is on the expenses of adequately funded pensions. Increased spending on programs for the elderly by 1983 is planned by the Federal government. Eight programs account for most of the Federal expenditures: Social Security, hospital insurance, physician's insurance under Medicare, Medicaid, Supplemental Security Income, Civil Service retirement, military retirement, and railroad retirement. Two areas where the elderly needed additional assistance are outpatient drug costs and long term nonhospital treatment. With regard to long term nonhospital care, critics contend that restricting the use of Medicaid to nursing homes is both economically and psychologically debilitating. The difficult state of finances that many elderly persons experience can complicate consideration of the issues involved in programs and expenditures for the elderly.

2. Mitchel, Monroe. Practical Guide to Long Term Care and Health Services Administration. Greenvale, NY: Panel Publishers, 1978.

Views on long term health care contributed by experts in health care delivery for the elderly are presented. Topics covered in this revised edition include management concepts and techniques, clinical information, psychotherapeutic approaches, rehabilitation modalities, and professional supportive services. There is increased emphasis on administrative theory and practice. Attention is given to organizational processes, functional programming, personnel programs, legal aspects, budget preparation, and record keeping. Clinical terminology is defined as a basis for a discussion of gerontological nursing, medical problems inherent in the aging, geriatr medicine, and the psychiatric aspects of aging. Rehabilitation techniques described include reality orientation, social processes, therapeutic recreation for institutionalized persons, pastoral care, and nutrition services. A historical view is given of the Medicare and Medicaid programs as they are applied in nursing homes. The overall viewpoint documented is that long term health care concepts are most usefully derived from empirical, dynamic experiences and problems encountered by those directly involved with nursing home administration.

3. U.S., Congress, House, Select Committee on Aging, Subcommittee on Health and Long Term Care. Recent Medicaid Cutbacks: Shocking Impact on the Elderly. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1978.

This April 1977 testimony before the Select Committee on Aging of the House of Representatives dramatically underscores the problem of Medicaid cutbacks for the elderly and suggests some possible solutions. Among the nine speakers were several representatives, Governor Garrahy of Rhode Island, and Sam Thurmond, Medicaid adviser in Georgia. The problem is simply stated: facing budget deficits, at least 20 States have curtailed Medicaid benefits since 1975, eliminating some services outright and severely restricting others. Meanwhile Federal, State, and local expenditures increased from $3.5 billion in 1968 to an estimated $14 billion in 1976. Four problem areas must be reformed: the sources of rising costs, gaps in coverage of the poor and needy, limits on benefits and limited participation by mainstream medicine, and inequitable distribution of benefits by State, urban-rural residence, and race. Preventive rather than crisis intervention or long term care programs should be stressed. Governor Garrahy suggests investigation of coverage for skilled nursing facilities, additional Federal matching funds for institutional-type services, copayment and deductible factors for Medicaid eligibles, and financial incentives for alternatives to institutional care. Comprehensive services for the elderly should include home health care, day care, housing for the handicapped, nutrition and transportation, etc. Cost containment can be effected through controls on the hospital industry and systematic incentives for efficient health care. Statements by the American Optometric Association and National Association of Dental Laboratories are appended.

4. Comptroller General of the United States. State Audits to Identify Medicaid Overpayments to Nursing Homes. Washington, DC: U.S. General Accounting Office, 1977.

Each year nursing homes must submit their costs to State agencies to obtain reimbursement from Medicaid. There is concern that a significant amount of overpayment is being made, based on undetected, unallowable costs or fraudulent claims. This report examines that issue, both with respect to the amount of and reasons for overpayment and the ability of State agencies to detect problems. Three major types of unallowed costs were identified: 1) nursing homes failing to offset certain costs related to income; 2) costs not directly related to patient care; and 3) unsupported or 'paper' costs. In this study, $300 million in total costs submitted by nursing homes were examined. It was found that States did not allow 3 percent, or approximately $9 million, and another 2.4 percent was not allowed because of ceilings. A Government Accounting Office (GAO) audit of $35 million in claims uncovered $0.8 million in overpayments (for the same nursing homes). States rely on field audits to detect fraudulent claims. GAO discovered States' efforts to conduct efficient field audits varied greatly, and there was generally a backlog. States also lacked recoupment procedures for cases of overpayments. The report recommends that HEW assess States periodically and deny Federal participation in States which do not have established recoupment procedures.

5. Wisconsin Nursing Home Ombudsman Program. Wisconsin Nursing Home Ombudsman Program. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

The activities of a Statewide ombudsman project established in Wisconsin to respond to nursing home patients' complaints regarding the quality of their care are described. Ombudsman offices in three cities receive complaints, usually from nursing home residents or their families, by mail or telephone. Each complaint is either referred to a more appropriate agency or investigated by the ombudsman staff. If the complaint is found to be justified, action to resolve the problem and to prevent its recurrence is begun. The ombudsman office may act as a consultant or a mediator. When attempts at negotiation and conciliation fail or are inappropriate, the complainant is referred to another agency that is empowered to deal with the matter. The ombudsman staff also gathers and analyzes data on nursing home issues and takes advocate positions. Breakdowns are presented of the sources and types of complaints received by the ombudsman office from 1972 through 1976 and of the types of facilities involved. Other agencies with which the ombudsman program works are noted. Problems on which the ombudsman program has had measurable impact are discussed, including the need for improvement of nursing home regulations, noncompliance with regulations, inappropriate reliance on nursing homes for mental health care, lack of alternatives to nursing homes, limited scope of Medicaid-covered services, and others.

6. Steinbach, Leonard. Nursing Home Ombudsman Services for the Elderly: Program Development Handbook for State and Area Agencies. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

This handbook on nursing home ombudsman services is one in a series of handbooks that focus on alternative service arrangements for the elderly, including multipurpose senior centers, information and referral services, homemaker and home health services, legal services, residential repair and renovation services, and employment services. Materials contained in the ombudsman handbook were derived from a review of available information on nursing home ombudsman services; site visits to two DHEW regional offices, three State agencies on aging, and six area agencies on aging; and discussions with four experts in the nursing home ombudsman field. The handbook is organized according to six sections: (1) the importance of nursing home ombudsman services to the elderly; (2) the long term care network and legislation (Medicare, Medicaid, Federal and State agencies, regional and local agencies, and legislation and regulations); (3) service definitions; (4) alternative models of nursing home ombudsman service delivery (lead agency, single agency, and committee concepts); (5) the role of State and area agencies in a nursing home ombudsman program (program development, advocacy, funding, monitoring and assessment, and training and technical assistance); and (6) provider operations. An annotated bibliography is provided. Additional information and forms pertinent to ombudsman services are appended.

7. Tolkoff-Rubin, Nina E., et al. "Coordinated Home Care -- The Massachusetts General Hospital Experience." Medical Care, 16/6 (1978): 453-464.

The experience of the Massachusetts General Hospital with a home care program coordinated with the Visiting Nurse Association (VNA) is described as a viable, economically feasible alternative to institutionalization for selected patients. Three major groups of patients have been effectively cared for in this program: patients with multisystem chronic illness, patients with terminal malignancies, and patients with catastrophic neurologic disease. The goals of the program relate to better posthospitalization care for patients, shorter duration of acute hospitalization without compromising quality of care, and more patients at home and out of institutions for the chronically ill. Services possible under the program are nursing care, Social Service and counseling, occupational/physical/speech therapy, nutritional/homemaker/home health aide services, and transportation. Patients who are accepted into the program must meet certain criteria, including residence in one of the communities served by VNA, commitment by the patient and his family to try to maintain the patient at home, significant medical disability requiring support of some of the services listed, and agreement by the physician and the home care team that a trial of the program would be in the best interests of the patient and the family. Once the home care plan is established for a patient, coverage continues until death, chronic institutionalization, or significant improvement. Funding for most program patients comes from third-party payment sources, e.g., Medicare, Medicaid, and private insurance companies. It is concluded that the program allows better utilization of the hospital facilities as well as more appropriate coordination and use of existing community health care resources.

8. Williams, T. F., et al. Evaluation-Placement of the Chronically Ill and Aged: Final Report and Executive Summary. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

The study evaluated the clinical outcomes and costs of the operation of the evaluation and placement service for chronically ill and aged patients. The service was assigned stratified test and control groups of Medicaid applicants for nursing home care. Periodic reassessments of patients in both groups were made. Findings: through utilization of a comprehensive medical-nursing-social evaluation and placement assistance system, significantly more appropriate placements can be achieved. It was more beneficial to evaluate and assist elderly or chronically ill persons early -- while they were still at home -- rather than waiting until their health and functional status had deteriorated to a point requiring intensive services. The study clearly demonstrated the benefits of more frequent re-evaluations within six months of the placement, when most movement within the system occurred. Multiple levels of care within a single facility were preferable to separate single-level facilities, both in terms of earlier transfer to lower levels of care and less trauma to the person when transfers were necessary.

9. Cantor, Marjorie, and Mayer, Mary. "Health and the Inner City Elderly." The Gerontologist, 16/1 (1976): TI.

A profile of elderly residents in New York City was developed that considered the health status of respondents, their utilization of health services, and problems related to obtaining adequate care. Home interviews were conducted during 1970 with a probability sample of 1,552 persons 60 years of age and older who resided in 26 of the city's poorest neighborhoods. Respondents constituted a low-income urban population, with 49 percent white, 37 percent black, and 13 percent Spanish-speaking. Most had a primary support system made up of family and neighbors. The respondent's own evaluation of his health and the Townsend Index of Functional Ability were employed to describe health status. Most felt that their health was fair (42 percent) or poor (24 percent). Only one-third reported that they were in good health. Income appeared to be the overriding factor with respect to health status. Differences among the study population also related to ethnicity. The poor health status of the elderly, including the high incidence of chronicity, was viewed as indicative of the need for medical services. The majority reported that they had been seen by a physician during the past year, although the 13 percent who had visited a physician had not received any medical attention for 3 years or longer. White respondents were almost universally covered by Medicare, but only 22 percent had Medicaid as compared with 41 percent of black respondents and 52 percent of Spanish-speaking respondents. There were noticeable differences in the use of hospitals; all but 10 percent of the sample had insurance. Major issues to be resolved in meeting the health care needs of the elderly are discussed.

10. Lah, Benjamin, and Stowell, Beryl S. "Dental Care for Nursing Home Patients." Public Health Reports, 93/1 (1978): 90-92.

The need for dental care among elderly patients in nursing homes is addressed in this article. To stimulate the provision of dental care to the elderly, DHEW's Health Resources Administration entered into a contract with the American Society of Geriatric Dentistry to conduct a series of 10 regional seminars for training dentists, auxiliary dental personnel, and nursing home personnel in oral health for nursing home patients. The seminars were conducted in collaboration with the American Dental Association in 10 cities throughout the United States over an 18 month period. Each seminar workshop provided at least 14 hours of training for about 40 dentists and dental auxiliaries and for 30 nursing home personnel. Speakers and workshop leaders for the seminars were selected from dental school faculty and practicing dentists. Dental techniques and practices for nursing home patients were discussed, and information was provided on alternative arrangements for delivering dental services to delivering dental services to Medicare and Medicaid patients. Services needed by nursing home patients that can only be provided by the dental profession are rebasing and repairing dentures, making new dentures, identifying dentures, performing extractions, treating periodontal disease, detecting oral cancer, and providing dental health education. Barriers to the provision of dental care in nursing homes are identified, and recommendations resulting from the 10 seminars are delineated.

11. U.S., Congress, House, Subcommittee on Health and Long Term Care. Tragedy of Multiple Death Nursing Home Fires: The Need for a National Commitment to Safety. Washington, DC: Government Printing Office, Superintendent of Documents, 1976.

Rationale for enactment of Federal legislation requiring installation of automatic sprinkler systems in Medicare and Medicaid nursing homes is presented in a report to the 94th Congress. The study on which the report is based was prompted by the experience of Chicago, Ill. Two fires in Chicago nursing homes killed 32 people and injured 50 others, while a third was extinguished quickly, with no loss of life or injury, by an automatic sprinkler system. The City of Chicago then enacted an ordinance requiring all nursing homes to install sprinkler systems. Several reports, including one from the National Bureau of Standards of the Department of Commerce, are cited to demonstrate that automatic sprinklers are the best known way to prevent multiple-death fires in nursing homes. The cost of requiring all nursing homes to be fully protected with sprinkler systems is estimated at $0.19 per bed per day. The total national cost is estimated at $256 million to $412 million for the 8,000 Medicare and Medicaid nursing facilities (out of a total of 16,500) without sprinklers at the time of the report. The provision of direct Federal loans is viewed as the most expedient way to insure the availability of the $32,000 to $50,000 per facility required to install the sprinkler systems. Copies of related House Bills are included.

12. U.S., Department of Health, Education,and Welfare. Office of the Assistant Secretary for Health. Office of Nursing Home Affairs. "How to Select a Nursing Home." Washington, DC: Government Printing Office, Superintendent of Documents 1977.

The highlights of a 1974 DHEW survey of long term care facilities and the essential facts needed by consumers who may be choosing such facilities are presented in a booklet that is also designed to serve as a reference tool for professional health workers assisting patients in selecting a health care facility best suited to the patient's needs. The booklet is organized into three sections: (1) questions asked about nursing homes; (2) choosing a nursing home; and (3) nursing home checklist. The most commonly asked questions concern the kind of nursing home, the typical patient in a home, the nursing home ownership and management, nursing home regulations, nursing home services, Medicare and Medicaid, and patient's rights. Steps involved in selecting a nursing home included consulting others, finding out what kind of home is needed, deciding on the location, locating nursing homes, narrowing the field, visiting nursing homes, meeting with key personnel, touring the home, making followup visits, checking costs, making the decision, making the selection, and following up. A checklist of important points to consider should be helpful in preparing for a visit, meeting staff, and comparing homes. Items on the checklist pertain to general physical considerations; safety; medical, dental, and other services; nursing services; food services; rehabilitation therapy; social services and patient activities; patients' rooms; and financial matters.

13. U.S., Congress, Senate, Subcommittee on Long Term Care. The Role of Nursing Homes in Caring for Discharged Mental Patients (And the Birth of a For-Profit Boarding Home Industry). No. 7. Nursing Home Care in the United States: Failure in Public Policy. Washington, DC: Government Printing Office, Superintendent of Documents, 1976.

The growing trend of placing former mental patients into nursing homes and boarding homes is discussed in one of a series of documents on nursing home care in the United States. Following notes about other papers in the series, the paper discusses the mental health care needs of the aged. Specifically discussed are the 'senility' barrier (it is noted that there is little agreement on the definitions of 'senility' and 'mental illness') and shortcomings in Medicare, Medicaid, and community mental health programs. The section on the exodus from State mental hospitals documents sharp reductions in the number of patients in mental hospitals and examines the reasons for transfers. The third section examines placement of patients and the quality of life for them in the alternative settings, focusing on how well nursing homes handle these patients and on the boarding home crisis. Specific examples of the experiences of many States are included. In the fourth section, Illinois and New York have been selected for in-depth analysis of the effect of transferring mental patients from State hospitals into boarding homes. Among the major points of the study are that 2 1/2 million elderly are going without needed mental health services, that programs designed to assist the mentally impaired elderly are ineffective and poorly administered, and that responsibility for mental health programs is fragmented among dozens of Federal, State, and local agencies. A list of recommendations and photographs accompany the text. Appended material deals with contract services and projects to relocate patients in New Jersey.

14. Lezer, Leon R. "Medical Direction of Long Term Care Facilities: Need for Established Standards of Performance." Long Term Care and Health Services Administration Quarterly, 1/1 (1977): 59-70.

Performance guidelines are presented for the medical director of a long term care facility (LTCF). The guidelines were developed by the American Medical Association's Committee on Aging in response to Federal requirements on medical direction in skilled nursing facilities for retaining Medicare and Medicaid certification. One of the most important requirements stipulated in Federal regulations is considered to be the development of a patient care plan within 7 days of admission to an LTCF. In the State of New York, a patient care plan must be developed within 14 days. The recommended content of a patient care plan is detailed and its importance to medical audit and progress notes is stressed. The need for patient histories, physical examinations, and laboratory data is discussed. Progress notes are viewed as an indication of patient status. Consultations and recurrent assessments are noted as significant elements to be considered by the medical director of an LTCF. Deficiencies frequently occurring in LTCF's are cited. The basic function of the medical director is defined as assisting physicians in quality care assurance. Medical audit and patient care plan forms are included for use by the medical director to assess the quality of care provided by attending physicians.

15. U.S., Department of Health, Education, and Welfare. Health Resources Administration, and American Medical Association. Medical Director in the Long Term Care Facility. Chicago, IL: American Medical Association, 1977.

In response to January 1, 1976, Medicare and Medicaid requirements for medical direction in Skilled Nursing Facilities, this collection of articles and memorandums is presented to assist the medical director in assuring high quality care for each patient. Among the specific topics are the history and development of the medical director concept; American Medical Association guidelines for the medical director of a long term care facility; the physician's role in the nursing home; the medical director of skilled nursing facilities; a proposal for a medical director's group (a concept designed to provide medical director services of a high quality on a contract basis to participating nursing homes); role relationships, with particular attention given to the role relationship between the director of nursing practice and services and the medical director; and the administrator's viewpoint of the physician's role in long term care. Other papers discuss issues such as the nursing home medical director and quality care; the nature of the medical directorship, its sources of authority and administrative responsibility, its legal responsibilities, and implementation of the medical director requirement; Federal regulations and proposed duties for the director in a skilled nursing facility; administrative medicine in the long term care facility; and myths about the aged. The memorandums, which originate from both Federal (DHEW) and State sources (Maryland, New York, and Texas), are concerned with various aspects of medical direction, including implementation of 'conditions of participation,' certification or recertification, status of the medical director with respect to membership on a facility's utilization review committee, and medical direction guidelines and requirements.

16. Abdellah, Faye G., and Chow, Rita K. "Long Term Care Facility Improvement: A Nationwide Research Effort." Journal of Long Term Care Administration, 4/1 (1976): 5-19.

A survey of skilled nursing facilities (SNF's) was conducted in 1974 to collect baseline data for the Federal long term care facility improvement campaign. A two-stage stratified random sampling design was employed to select a study sample from 7,526 SNF's participating in Medicare and Medicaid programs in 1974. A sample of patients was drawn from 288 selected SNF's. Study teams collecting data for the survey included a physician, nurse, administrator, nutritionist, pharmacist, physical therapist, fire safety engineer, and a social worker. Survey instruments were designed to assess the cost and quality of care rendered in SNF's, including the physical, nutritional, rehabilitative, and mental health status of residents. Four forms were used to collect data about the facility: identifying form, financial form, fire safety form, and facility-specific form. Forms utilized to collect patient data were the patient assessment form and the patient-specific form. Survey data reported describing patient characteristics, health care needs of patients and residents, nutritional needs, pharmaceutical services, physician services, rehabilitative services, health professional involvement, administrative and fiscal management, health and

safety of the environment, and social services. Five needs were identified as the result of the survey: (1) review the survey and certification process; (2) achieve nationwide training, credentialing, certification, and licensure of State surveyors; (3) analyze the entire fiscal approach of reimbursement of facilities for services provided; (4) give high priority to alternatives to institutional care; and (5) intensify the training of health personnel at all levels.

17. Comptroller General of the United States. Federal Fire Safety Requirements Do Not Insure Life Safety in Nursing Home Fires. Washington, DC: U.S. General Accounting Office, 1976.

Federal fire safety requirements for nursing homes participating in Medicare and Medicaid are discussed in a report of the Comptroller General to the Congress. The report examines two fires in Chicago nursing homes that led to the deaths of 31 people early in 1976. Multiple deaths occurred in these and other fires even though the buildings were considered to be fire resistive and were in substantial compliance with Federal fire safety requirements. Investigation of the Chicago fires revealed that the deaths were caused by smoke and products of combustion rather than by flames. Neither facility was fully protected with an automatic sprinkler system designed to activate an alarm and begin combating the fire immediately. Neither the fire department, which responded promptly to both alarms, nor facility employees were able to prevent the deaths. This and other reports point up the need for and the benefits of automatic sprinkler systems in nursing facilities. It is estimated that the cost of sprinkler system installation ranges from $393 to $625 per bed. It is pointed out that, with the installation of a sprinkler system, savings on nursing facility fire insurance premiums are possible. Through reimbursement for depreciation and interest, Medicare and Medicaid will pay for part of the cost of installation. The report recommends that Congress enact legislation requiring all nursing facilities to be fully protected with automatic sprinkler systems. It is further recommended that the Department of Housing and Urban Development take steps to encourage the use of Federal loan insurance for the installation of fire safety equipment, a program hampered by excessive processing time and lack of publicity. Appended materials include a summary of pertinent Congressional Committee reports on fire safety in nursing homes, copies of the floor plans of the two Chicago facilities, and details of other nursing facility fires resulting in multiple deaths.

18. Ruchlin, H. S. "A New Strategy for Regulating Long Term Care Facilities." Journal of Health, Politics, Policy, and Law, 2/2 (1977): 190-211.

This study analyzes the failure of current regulatory efforts to elicit an acceptable level of performance in long term care facilities and proposes a strategy for correcting that failure. Seven factors are identified as being responsible for the failure of current regulatory efforts: inadequate financing, inadequate knowledge, bureaucratic apathy, legal constraints, political constraints, a fragmentation of agency responsibility, and a shortage of conforming beds. Public utility status, market regulation, and non-profit control are reviewed and rejected as alternatives to the current

approach. A new strategy aimed at improving the regulatory process and environment is proposed. The process can be improved by adopting a program rather than taking a functional approach to agency organization; linking the inspection and rate-setting processes; creating a role for consumer groups in the inspection process; and exposing the process and results of regulation to public scrutiny. Five proposals are offered for improving the regulatory environment. These focus on eliminating barriers to entry, supporting alternatives to institutionalization, Federalizing the Medicaid program, abandoning exclusive reliance on the medical model as the guide for regulatory standards, and changing the focus of regulation from structure-process to out-come.

SECTION VI

Public Issues and Policies

1. Crockett, Pernell W. Health Insurance: Public Programs (A Bibliography with Abstracts). Final Report. for 1971-May 78. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1978.

References are presented on the evaluation, utilization, administration, and financial management of government health insurance programs. The bulk of the citations pertain to the Medicaid and Medicare programs. Reports are also included on the Medicaid Management Information System and the Civilian Health and Medical Program for Uniformed Services (CHAMPUS). (This updated bibliography contains 270 abstracts, 120 of which are new entries to the previous edition.)

2. Iglehart, John K. "New Strategy for Medicare and Medicaid." National Journal, 8 (1978): 471-473.

Possible reforms in the administration of the Medicare and Medicaid programs are noted. Since Medicare and Medicaid are entitlement programs that finance health services to the elderly and the poor, spending is virtually uncontrollable and the programs have come to dominate Federal health spending. The Carter Administration's fiscal year 1979 budget estimates that spending for Medicare will increase to $29.4 billion and that spending for Medicaid will increase to $12.1 billion. State and local government spending for Medicaid is expected to reach $9.2 billion in fiscal year 1979. In States such as California and New York, Medicaid has become more costly than welfare. In a strategy paper issued by DHEW, the most expensive proposed reforms will broaden the eligibility standards of Medicaid at an estimated additional Federal-State cost of $3.4 to $5.9 billion. These reforms reflect the philosophy of the strategy paper that the Federal government rather than States should control Medicaid policies. Recommended changes in how Medicare and Medicaid should pay providers of care are limited to physicians. The institution of Statewide physician fee schedules in both programs is proposed. It is through the integration of Medicare and Medicaid that the Health Care Financing Administration of DHEW sees some cost savings.

3. Chen, Milton; Stoga, Alan; and Foltz, Anne-Marie. Health Policy Project: The Differential Impact of Medicaid; Interstate Variation in Expenditures and Participation Time Lags. Interim Rept. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Medicaid is the principal source of medical care for the poor. Federal Medicaid contributions are weighted in favor of poor States. Program administration is left wholly to the States. This study assays policy variables among the States to determine the weight of Federal matching formulae, political party rivalry, health status and health care resources. The findings are that contrary to the axiom that States will maximize Federal funding by providing maximum matching funds, local income and resources are the prime determinants. Wealthy States qualify for maximum Federal matching funds; many of the poor States do not. Consequently the poor in poor States for whom health legislation was designed are denied equitable share of health care.

4. Holahan, John; Scanlon, William; and Spitz, Bruce. Impact of National Economic Conditions of Health Care of the Poor: Public Financing. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

The report, one of eight projects which analyze the impact of the 1974-75 economic recession on aspects of health, presents results of the impact of recession on costs, financing and utilization under the Medicaid program. Section I analyzes the program's financial experiences, concluding that, while unemployment and revenue losses contributed to fiscal strain and consequent cutback in benefits, the primary reason for deterioration was severe rate of inflation experienced in the health care market in general. States were classified as to severity of strain on their programs and detailed econometric analyses were made regarding their responses. Policy options which might be used by Federal and State governments to ameliorate such problems are addressed, including alternative financing, eligibility criteria, and reimbursement methods and utilization controls.

5. Rhein, Reginald W. "Health Cost 'Crisis'. The Carter-Califano Target -- Is It Really A Skyrocket?" Medical World News, 18/4 (1977): 57-60.

Factors influencing the significant increases in health care costs are addressed. Cost containment activities supported by the Carter Administration and by DHEW Secretary Califano are discussed. It is estimated that the United States spends $140 billion a year on health care. This high expenditure figure has an impact on both medical and nonmedical groups. Increased insurance premium costs in the government and industry are noted. In 1965, the average American paid $197.95 for health care; in 1972, this figure more than doubled to $409.71; and in 1976, the average American paid $637.97. The Council on Wage and Price Stability projects that per capita outlays for health will double again by 1981. The biggest component of the U.S. health dollar goes for hospital care. Physician services are next, followed by drugs and drug sundries, nursing home care, dentist services, medical facilities construction, and biomedical research. Causes for increased health care costs are considered to be excess hospital capacity, fee raising by physicians, the growth of medical insurance coverage, retrospective cost reimbursement, insurance reimbursement policies, the proliferation of government regulations, soaring medical malpractice insurance rates, lifestyles deemed improper, a lack of consumer knowledge, and the changing population. The impact of the introduction of Medicare and Medicaid is examined.

6. Davidson, Stephen M. "Understanding the Growth of Emergency Department Utilization." Medical Care, 16/2 (1978): 122-132.

Although there has been a substantial amount of research focusing on the patient population of emergency departments (ED's) and its use of services, the results have been inconclusive. The question of how the enormous growth in the utilization of emergency services can be accounted for has been left unresolved. This article suggests that it may be

better to ask why people choose the emergency room instead of another source of care, by focusing on enabling and illness characteristics rather than other factors. The paper offers the tentative explanation for the use of emergency department services, that increased demand for services due to Medicare and Medicaid assistance, fewer primary care physicians, and the potential of ED use for balancing lowered hospital occupancy rates have contributed to increasing ED use in inner city areas. Lack of accessibility to other sources is the underlying cause of the growth in nonurgent utilization of emergency rooms in the suburbs. This is partly due to an insufficient number of physicians -- fewer new physicians are entering private practice. Following the general explanation of utilization, the article reviews the literature to determine how much support exists for the interpretation offered, and identifies gaps in the literature.

7. Somers, Anne R., and Somers, Herman M. "Proposed Framework for Health and Health Care Policies." Inquiry, 14/2 (1977): 115-170.

Significant parameters in the formulation of health care policies are considered. It is felt that any health care system design, to be effective, must be based on two broad assumptions: (1) responsibility for personal health rests primarily with the individual and not with the government, physicians, hospitals, and third-party financing programs; and (2) if the individual's responsibility is to be effectively discharged, it must be supported by social policies designed to provide him or her with essential environmental protection, health information, and access to health care when needed. The overriding goal of a national health policy is stated as the creation and maintenance of conditions under which individuals are most able and most likely to optimize their own health potential. Particular attention is given to the importance of knowledge development (environmental, behavioral, and health services research), the environment (socioeconomic factors, occupational safety and health, and political and moral factors), and individual behavior and lifestyle. Personal health services are discussed in relation to economic relations among physicians, hospitals, and patients; quality and efficiency; limited resources; overcapitalization; universal access; essential services; the supply of physicians; legislation; hospitals and related facilities; quality protection; the malpractice controversy; Medicaid abuse; the appropriateness of care; costs, rate review, and physician reimbursement; competition; utilization; and hospital organization.

8. Aday, L. A; Andersen, R.; and Anderson, O. W. "Social Surveys and Health Policy Implications for National Health Insurance." Public Health Report, 92/6 (1977): 508-517.

The authors explore the utility of applying social survey data (a) to evaluate the impact of existing health programs and (b) to rank-order priorities concerning future health care policies. Based on national survey data from 1963, 1970, and 1976, they concluded that although Medicare and Medicaid have enabled more people to see a physician than ever before, a large proportion of the population still registers dissatisfaction with the

health care they received -- particularly with respect to their out-of-pocket costs for obtaining it. However, national health insurance options favored by the majority of the population -- particularly those who can best afford the cost of care -- suggest preferences for programs that incorporate some mix of existing modes of financing rather than those that provide for substantial restructuring of the current system.

SECTION VII

Alternatives to Institutionalization

1. Lowe, Janet. "Alternative to Hospitals." Modern Maturity, (Apr-May 1976): 29-31.

The trend toward home nursing care as an alternative to chronic institutionalization is examined. Studies have shown that a large percentage of hospital patients and nursing home residents could live at home if adequate home health services were available. With the recent disillusionment over the nursing home system and the rising cost of medical care, health care professionals at all levels are beginning to view home nursing care as a viable alternative. The effects of home nursing as studied in one group of stroke victims showed better outcomes than were found in a similar group of hospitalized subjects. Impediments to the expansion of home nursing care are the need for hospitals to keep utilization high to pay for capital investments, the convenience to the physician of having all patients centrally located where medical equipment and aides are, and the reluctance of some third-party payers to finance home care. New and pending legislation contains some provisions for clearing these impediments, such as the development of home health agencies and the training of home nursing personnel. The expansion of reimbursement qualifications under Medicare is also being considered. Criteria for Medicare payment of home nursing expenses are listed. Some criteria for judging whether home health care is a good solution in individual patient cases are also provided, taking into account living conditions and accessibility of the premises proposed.

2. Tolkoff-Rubin, Nina E., et al. "Coordinated Home Care -- The Massachusetts General Hospital Experience." Medical Care, 16/6 (1978): 453-464.

The experience of the Massachusetts General Hospital with a home care program coordinated with the Visiting Nurse Association (VNA) is described as a viable, economically feasible alternative to institutionalization for selected patients. Three major groups of patients have been effectively cared for in this program: patients with multisystem chronic illness, patients with terminal malignancies, and patients with catastrophic neurologic disease. The goals of the program relate to better posthospitalization care for patients, shorter duration of acute hospitalization without compromising quality of care, and more patients at home and out of institutions for the chronically ill. Services possible under the program are nursing care, social service and counseling, occupational/physical/speech therapy, nutritional/homemaker/home health aide services, and transportation. Patients who are accepted into the program must meet certain criteria, including residence in one of the communities served by the VNA, commitment by the patient and his family to try to maintain the patient at home, significant medical disability requiring support of some of the services listed, and agreement by the physician and the home care team that a trial of the program would be in the best interests of the patient and the family. Once the home care plan is established for a patient, coverage continues until death, chronic institutionalization, or significant improvement. Funding for most program patients comes from third-party payment sources, e.g., Medicare, Medicaid, and private insurance companies. It is concluded that the program allows better utilization of the hospital facilities as well as more appropriate coordination and use of existing community health care resources.

3. U.S. Department of Health, Education, and Welfare and National League for Nursing. Home Health Care -- A Discussion Paper. New York, NY: National League for Nursing, 1977.

The implications of expanding home health care are analyzed by an in-house HEW staff group formed in 1976-77 to assist administration policy formation in the home health industry; their recommendations to the Secretary are here made public. If home health care is to be expanded, its social utility must be balanced with cost considerations, as well as with the impact on State and local government, medical providers, and fiscal intermediaries. Two principal sections discuss the expansion of services and their management. The first section covers eligibility and services under Medicare and Medicaid, the administration's changing emphasis on aging, and promotion of the awareness and use of home health care services. The second section considers cost containment, coordination and planning, and quality assurance issues. One vital concern is overcoming the lack of awareness of and interest in home health care services on the part of health professionals and the public; expanded educational and training programs are proposed. The study also recommends: (1) a 'national experimental benefit period', which would provide expanded home health coverage by changing requirements for Medicare eligibility and by encouraging States to offer comparable benefits under Medicaid; (2) Medicare benefit changes in six areas; (3) local health agency certificates; and (4) other initiatives. Appendixes summarize pertinent legislation and regulations and include an updated six-page bibliography.

4. U.S. Department of Health, Education, and Welfare. Applied Management Sciences, and Office of the Assistant Secretary for Planning and Evaluation. Evaluation of Personal Care Organizations and Other In-Home Alternatives to Nursing Home Care for the Elderly and Long Term Disabled. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Research objectives of the study include efforts to: identify existing projects which serve as in-home alternatives to institutionalization, especially those which are in the process of evaluation; analyze materials describing in-home care projects for purposes of assessing the validity and reliability of findings on costs and effectiveness and/or cost-efficiencies from the standpoint of major threats to internal and external validity; assess the feasibility of conducting a prospective experimental study of clients served by major alternatives to long term inpatient care; and delineate requirements and scope of a prospective design. The results emphasized the need for such a prospective study in that project limitations provide only answers in the most qualified sense on the effectiveness and cost-efficiency of alternatives to institutionalization.

5. Wan, Thomas T. H. Access to Care, Health Status, and Health Services Utilization of Noninstitutionalized Older Persons in Low-Income Urban Areas. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

The study examines factors affecting the extent to which non-institutionalized elderly persons use ambulatory physician care and short term hospitalization. Multivariate analyses were performed for 1,987 elderly persons living in five neighborhood health center service areas. The majority of variance in health services utilization was explained by two health measures, namely, level of chronic disability and number of episodic illnesses. Those with a regular source of care were three times as likely as those with no regular care source to utilize ambulatory care. Medicaid recipients and neighborhood health center users were the most frequent users of ambulatory physician care, irrespective of race. It appears that the removal of financial barriers coupled with a concerted effort for making health services readily available to the medically needy has greatly facilitated the use of ambulatory care. For a given level of health, elderly blacks had more frequent physician contacts and relatively shorter stays in hospitals than elderly whites. Planned change of racial disparities in health care is suggested.

6. Ricker-Smith, Katherine, and Trager, Brahna. "In-Home Health Services in California -- Some Lessons for National Health Insurance." Medical Care, 15/3 (1978): 173-90.

Home health services provide an array of services to be brought into the home to sustain an optimum state of health, activity and independence for individuals of all ages who require such services because of acute illness, exacerbation of chronic illness, or disability. A fairly recent development in health care delivery, home health services have both expanded and declined because of support, or lack of support, from Medicare and Medicaid. This article describes the experience in California with home health care services. California was chosen because it did and still does account for a substantial proportion of such services and because the State collected at least minimal uniform annual data. The article offers six major conclusions: 1) differences in service utilization by age do not necessarily reflect differences in need by age; 2) in-home services are appropriate for long term as well as short term illnesses and disabilities; 3) chronic illness and disabilities frequently result in multiple diagnoses; 4) service needs of the chronically ill and disabled occur across a wide spectrum; 5) potential demand for in-home health services is great; and 6) failure to provide for a productive uniform data collection system precludes assessment, oversight, and forward planning.

7. Marathon County Health Council and North Central Area Health Planning Association. Home Health Care Services in Marathon County. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

This report reviews the programs that provide home health care services in Marathon County, Wis. It includes the cost benefits claimed by home health care services in other States, the types of services provided in Marathon County, and the financing of these services. It concludes with a summary of the findings and recommendations by the home health care committee, which wrote this report. Home health care services in Marathon County are provided by two agencies, the Wausau Visiting Nurses Association (VNA) and the Marathon County Health Department

(MCHD). The population of the county is about 105,000; the VNA serves about 67,000 and the MCHD about 38,000. In 1976, the VNA made 10,045 visits to 451 patients, while the MCHD made 1,450 visits to 108 patients. The types of services used most often were professional nursing services; next most frequent were home health aide services, physical therapy, occupational therapy, and homemaking. Other services available include occupational therapy, speech therapy, medical supplies, medical social services, home delivered meals, audiological and dental services, and transportation. Most of the funding is provided by Medicare and Medicaid, but to obtain such reimbursements the agencies must be accredited. Private insurance carriers provide about 13 percent in each case. Among the recommendations are that all home services be provided by the VNA, that home services be more closely coordinated with local hospitals, and that the agencies try to make their services more widely known and provide a wider mix.

8. Beattie, Robert T., and Jordan, Harmon S. Preliminary Analysis of a Survey of Massachusetts Hospital Patients Who Were Ready for Discharge and Awaiting Placement in Other Facilities on March 20, 1974. Springfield, VA: National Technical Informational Service, 1975.

The factors impeding the placement of patients in appropriate long term care facilities are assessed. On March 20, 1974, forms requesting information on patients who were medically ready for discharge from each hospital in Massachusetts and who were awaiting placement in nonacute care facilities were completed. Followup information was collected on each patient at the time of discharge, death, or change in condition obviating the need for placement. After 6 weeks, those patients still awaiting placement were categorized as not placed. Questionaires were also sent to each long term care facility licensed by the Massachusetts Department of Public Health to determine the number of patients and vacancies in the home on March 20, 1974. Of the 192 hospitals contacted, all but three responded, and only one of the 903 homes failed to respond. There were 2,021 patients awaiting placement. At the end of the 6 weeks, 41 percent had been placed, and 45 percent were still waiting. During the period from December 31, 1973 to May 1, 1974, the average waiting time of all patients was 55 days; this figure varied from 29 days for acute care hospitals to 87 days for patients in chronic and rehabilitation hospitals. It was also found that Medicaid patients waited considerably longer than those with other sources of payment. Tabular data are used, and figures, data collection instruments, a map of the region, and the distribution of acute care hospitals are appended.

9. Morris, Robert. Evaluation of the Worcester Massachusetts Home Care Project. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Home care is discussed as an alternative to institutionalization in Worcester, Mass. It was initially proposed that the experiment in home care focus primarily on substituting acceptable home care services for persons who might become patients in nursing homes without these services. The final experimental design was modified to evaluate improvements in health status, including such factors as increases in life expectancy. The experimental population included not only those who were

ineligible for Medicaid but also those for whom the degree of severity of disability and risk of institutionalization was obscured. It was proposed that the financing of home care services be made simple and controlled through a capitation mechanism and that an attempt be made to divert unnecessary nursing home expenditures into necessary home care services through reliance on Medicaid. It was also proposed that a personal care organization be established to serve as a primary home care provider. Difficulties encountered in the experimental project related to the absence of effective provision for Medicaid payments, an artificial case finding and screening procedure, and a small client population.

10. Lavor, Judith, and Callender, Marie. "Home Health Cost Effectiveness: What Are We Measuring." Medical Care, 14/10 (1976): 866-872.

A conceptual framework for relating levels of home care to purposes of home care is presented, and cost effectiveness studies of home care services are discussed within the framework. The two major purposes of home care are to keep people in their normal environments and to help people recuperate after an institutional stay. Three major levels of home care -- intensive, intermediate, and basic (maintenance) -- are defined. An intensive level of home care is appropriate to shorten institutional stays and follows an acute illness episode. Basic services prevent the need for institutional care. Intermediate home care permits a choice between care at home and care in an institution. The few cost effectiveness studies that have been made on home health care tend to ignore the impact on cost calculations of key health, demographic, social, and economic characteristics of the population served. While intensive home care might be very costly when compared with nursing home care, it is not costly when compared with hospital care. While home care will not always replace a hospital stay, it can shorten that stay. Other levels of home care should be examined in relation to equivalent levels of institutional care in order to be evaluated fairly. A review of Medicare - Medicaid expenditures for 1969, 1971, and 1973 reveals that expenditures for home health are miniscule compared with hospital and nursing home expenditures. The need to take a long-range view in considering the cost effectiveness of expanded home health benefits under Medicare and Medicaid is pointed out.

SECTION VIII

Medicaid Administration

1. Comptroller General of the United States. North Carolina's Medicaid Insurance Agreement: Contracting Procedures Need Improvement. Washington, DC: General Accounting Office, 1976.

A critical review is presented of North Carolina's Medicaid Insurance Agreement with Health Application Systems, Inc., in a report to the Subcommittee of Health of the U.S. Senate Committee on Finance. In April 1975, the State entered into a 2-year, $376 million insurance agreement with Health Application Systems which made the company responsible for paying all non-drug Medicaid claims and for assuming all administrative duties for the State's Medicaid program with exception of determining eligibility, inspecting and certifying providers, setting program policy, and paying the costs of year-end settlements with providers. Of 33 firms solicited, only Health Application Systems submitted a proposal for an insurance agreement. The report includes an analysis of North Carolina's contracting procedures and of the extent to which DHEW was involved in soliciting and awarding the contract. Although the State expected to derive several benefits from the contract, the analysis indicates that these benefits probably will not materialize, at least not as a direct result of the insuring agreement. It is suggested that North Carolina's approach to controlling increasing Medicaid costs by negotiating an insurance agreement with a private contractor could be improved by encouraging competition and by evaluating proposed contract prices more carefully. Comments on the report by DHEW, the State of North Carolina, and Health Application Systems are included.

2. U.S., Department of Health, Education, and Welfare. Health Care Financing Administration and National Institute for Advanced Studies. Evaluation of Medicaid Administrative Costs. Final Report. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1978.

The report presents the findings of an analysis of the costs and revenues of State administration of the Medicaid program (Title XIX of the Social Security Act). Federal funding of the Medicaid program consists of payments for basic health care services to eligible individuals (Medical Assistance payments) and financial support to State agencies for administering the program. The purpose of this study is to provide the Health Care Financing Administration, which has Federal responsibility for the Medicaid program, with a more detailed understanding of the effects of Federal policies relating to Federal support of Medicaid administrative costs.

3. Morey, Richard C.; Crane, Michael A.; and Nawrocke, Paul. Medicaid Performance Standards Feasibility Study: Report for 1 Jul 76-31 Jun 77. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1978.

The overall purpose of this study was fourfold: (1) to identify areas in Medicaid most amenable to quantitative performance; (2) to develop quantitative standards for these areas; (3) to assess the potential im-

pact of such standards upon the program; (4) and to compare current costs and manpower needs with the projected levels necessary for performance standards. The contractor consulted HEW central and regional offices, and State agency personnel during the development of each standard. The areas for which the standards were developed were: (1) Early and Periodic Screening, Diagnosis, and Treatment, (2) third party collections, (3) erroneous payments, (4) provider participation, (5) provider fraud and abuse.

4. Newman, Alan S., et al. Alternate Methods for Describing Physician Services Performed and Billed: Phase II. Research Report. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1978.

The report summarizes the impact upon the Medicaid program and its system for processing claims for physician services stemming from a change in the medical procedural terminology and coding system used to bill and administer claims payments. The study analyzed a natural experiment by relating 12 months of experience after conversion to a system based upon the American Medical Association's 'Current Procedural Terminology 3rd Edition' to the experience and trends under the former Virginia Medical Assistance Program Terminology and Coding System.

5. U.S., Department of Health, Education, and Welfare. Social and Rehabilitation Service (now Health Care Financing Administration), and Control Analysis Corporation. An Evaluation of Erroneous Expenditures. Volume III. Final Report. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Volume III serves as an executive summary. A 1976 modification will include a software package for States to use in reprocessing claims already paid to check for errors, and a test package for Federal use in checking State edit procedures.

6. General Accounting Office, Health Resources Division. Supplemental Security Income Overpayments to Medicaid Nursing Home Residents Can Be Reduced: Department of Health, Education, and Welfare. Social Security Administration. Health Care Financing Administration. Report to the Congress. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Admission to a nursing home should result in a reduction of supplemental security income benefits because the individual's care is provided under the Medicaid program. Supplemental security income overpayments, however, are made because the Social Security Administration is not aware of recipient admissions to nursing homes. In California and Florida these overpayments amounted to $7.6 million during 1975. Social Security's reliance on recipients to report admissions has not been effective. Nursing homes are a good source of information on admissions, and GAO recommends that they be used to report recipient admissions.

7. Nebraska State Department of Public Welfare. Optometrists Handbook. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

This handbook provides supporting documentation for the evaluation of the Medicaid Management Information System of the Nebraska Department of Public Welfare. Among the subjects discussed are: provider agreement, medical care standards, prior authorization; services rendered outside Nebraska; freedom of choice; documentation of services; lock-in procedure; approval; payment in full; procedures and codes; maximum fees; and Medicare and Medicaid. Instructions for completing forms are presented, and paid claims listing and claim adjustments are examined.

8. Anderson, John C., and Farseth, Paul. "Implementing the Model Medicaid Management Information System." Public Health Reports, 92/2 (1977): 135-146.

Minnesota's experience with the implementation of the model Medicaid Management Information System (MMIS) is reported. It is felt that the MMIS is a feasible design for the administration of Medicaid, even though it is sometimes difficult to integrate and implement. Historical events in the development of the MMIS are reviewed and its implementation in Minnesota is discussed. Six areas in which problems may arise during the course of an MMIS effort are identified: defining program and operations policies, organization planning and defining of roles, managing and controlling a project, defining data and output requirements, provider relations and training, and coping with technological change. The importance of the cooperation of Medicare fiscal agents, State health departments, Professional Standards Review Organizations, and other compensation systems is noted. It is emphasized that sufficiency, acquirability, reliability, and consistency of data must be assured in an MMIS effort. Four major elements in provider relations and training for an MMIS are marketing, tapping information resources, training, and troubleshooting. Technological change relates to the use of computer and terminal hardware, borrowed programs in nonstandard computer language or which do not match their documentation, optically scanned vendor invoices, data display media, and provider and service bureau computer limitations.

9. Comptroller General of The United States. Improvements Needed in Managing and Monitoring Patients' Funds Maintained by Skilled Nursing Facilities and Intermediate Care Facilities. Washington, DC: General Accounting Office, 1976.

Mismanagement of patients' personal funds in Medicaid long term care facilities in five States is discussed and proposals for dealing with the problem are suggested in a report to the U.S. Senate Subcommittee on Long Term Care, Special Committee on Aging. The report is based on a review of DHEW regulations and State monitoring procedures in California, Florida, Michigan, Missouri, and New York, and on a review of the procedures used to manage and account for patients' funds in 30 skilled nursing and intermediate care facilities in these States. The report reveals inadequacies in Federal and State regulations and guidelines for handling patients' funds, major and procedural deficiencies in the handling of patients' funds by the facilities, and shortcomings in the State monitoring practices. Among the problems found in the facilities were shortages in patients' funds, practices of charging medical supplies and services to patients' funds, keeping funds of deceased or transferred patients, and keeping interest earned on patients' funds. It is recommended that DHEW issue additional regulations

designed to safeguard patients' funds, that State inspectors be trained to identify problems in the management of patients' funds, and the States be urged to modify common audit agreements with Medicare intermediaries to include a review of patients' funds at skilled nursing facilities.

10. Comptroller General of The United States. State Audits to Identify Medicaid Overpayments to Nursing Homes. Washington, DC: General Accounting Office, 1977.

Each year nursing homes must submit their costs to State agencies to obtain reimbursement from Medicaid. There is concern that a significant amount of overpayment is being made, based on undetected, unallowable costs or fraudulent claims. This report examines that issue, both with respect to the amount of and reasons for overpayment and the ability of State agencies to detect problems. Three major types of unallowed costs were identified: 1) nursing homes failing to offset certain costs related to income; 2) costs not directly related to patient care; and 3) unsupported or 'paper' costs. In this study, $300 million in total costs submitted by nursing homes were examined. It was found that States did not allow 3 percent, or approximately $9 million, and another 2.4 percent was not allowed because of ceilings. A Government Accounting Office (GAO) audit of $35 million in claims uncovered $0.8 million in overpayments (for the same nursing homes). States rely on field audits to detect fraudulent claims. GAO discovered States' efforts to conduct efficient field audits varied greatly, and there was generally a backlog. States also lacked recoupment procedures for cases of overpayments. The report recommends that HEW assess States periodically and deny Federal participation in States which do not have established recoupment procedures.

11. Levey, Samuel, and Loomba, N. Paul. Long Term Care Administration: A Managerial Perspective. Vol. II. Jamaica, NY: Spectrum, 1977.

Eighteen readings included in this book deal with the management of long term care. Four readings examine the role of government in long term care (Government and Health, Medicare and Medicaid, Government Support of Nursing Home Care, and Massachusetts Nursing Homes in Transition). In four readings on planning, consideration is given to making planning effective, health planning and a method for generating program objectives, management by objectives, and a framework for management information systems. Readings in the evaluation and control section concern the evaluation of health care, the appraisal of nursing home care, and the survey and critical evaluation of long term care reimbursement policies under Medicaid. Three readings pertain to the effective manager (management of change, understanding and organization's character, and the general manager). Other readings discuss the long term care market place and educational planning for long term care administration. A bibliography, a subject index, and an author index are included.

12. Rosenthal, J., and Schwartz, K. "Modifying the Pattern of Prescribing Multiple Pairs of Glasses." American Journal of Optometry and Physiological Optics, 55/1 (1978): 52-56.

The New York City Medicaid Program uses computerized monitoring techniques as part of its effort to control the quality and utilization of services. The system can identify certain aberrant patterns of practice. For optometric services, one such practice by some providers is the prescribing of separate distance and near eyeglasses in lieu of bifocals. Sending a notification letter to these providers succeeded in modifying the practice. Computerized monitoring and association roles for professionals are discussed.

13. Davidson, S. M. "Variations in State Medicaid Programs." Journal of Health, Politics, Policy and Law, 3/1 (1978), 54-70.

Many Federal laws permit the States considerable latitude in determining the important characteristics of programs created under them. Yet, frequently this aspect is overlooked in the analyses of differences in State-level programs. The purpose of this paper is to present a measure to aid in the analysis of one such program, Medicaid, and to illustrate some of the ways it can be useful. The Medicaid Program Index (MPI) differentiates among State Medicaid programs according to four important characteristics: inclusion of the medically indigent, the optional services covered, limitations on the provision of the basic services, and arrangements for paying providers. Data are presented to show that, in fact, the States do vary considerably on these factors, which can be analyzed in the aggregate (i.e., as the MPI) or separately. In addition, several uses for the MPI are discussed. They include: (1) identifying variations in State programs; (2) accounting for those differences by comparing them to promising explanatory variables; (3) identifying trends in program characteristics over time: and (4) developing hypotheses to account for those trends. Finally, it was suggested that similar measures can be developed to facilitate analyses of other Federal/State programs.

SECTION IX

Reimbursement and Cost Control

1. Kinzer, David M. "Health Controls Out of Control: Warnings to the Nation from Massachusetts." Chicago, IL: Teach 'Em, 1977.

In this report the President of the Massachusetts Hospital makes a number of observations about the health regulatory system in Massachusetts and offers suggestions for making the system in general more effective. Following a brief overview of the new public dimension of regulation, the discussion turns to a detailed examination of the Massachusetts health services environment and the State's hospital control system. With this background established, some critical deficiencies in the system are identified. Among the areas addressed are the lack of coordination, the irrelevance of hospital licensure, difficulties of enforcement, the lack of incentives to control costs and to improve efficiency, and the need for integrated data systems. It is pointed out that two irreconcilables -- the State government's closed-budget system and the health care delivery sector's open-budget system -- must be reconciled, since health services have grown to the point where this sector can no longer flourish economically when other sectors of the economy are slowing down. The point is made that the Massachusetts control system is stultifying to the system and that change and innovation are discouraged. The discussion concludes with a series of statements detailing what might be done about the problems with the health regulatory system. It is noted that although these comments follow from the observations about the imperfections in the Massachusetts system, the issues do not differ significantly from those to be encountered by other States and the nation as a whole. A bibliography is included.

2. Schweitzer, Stuart O., and Record, Jane Cassels. "Third-Party Payments for New Health Professionals: An Alternative to Fractional Reimbursement in Outpatient Care." Public Health Reports, 92/6 (1977): 518-526.

In an effort to relieve overworked physicians and provide better health care in unserved or underserved areas, programs to train new health professionals (NHP's) (physicians' assistants, medex personnel, and nurse practitioners) were instituted in the 1960's, an era of increased health care needs awareness. One of the problems arising from the availability of NHP's to provide primary care services is the amount of reimbursement for these services that should be paid by Medicaid, Medicare, and private insurance plans. Opinions range from 0 to 100 percent of physicians' fees as reimbursable for services rendered by NHP's, depending on whether one considers the service rendered equal to that of the physician or as a subspecialty and reimbursed at a lower rate or not reimbursed at all. The object is to avoid windfall profits to individuals or organizations charging physicians' fees to third-party payers for services of NHP's and paying NHP's less than physicians. After a discussion of the amount of physicians' workloads delegable to NHP's and a statistical evaluation of the cost savings potential in the use of NHP's services, the authors suggest a reimbursement proposal comparable to that provided other health technologists, i.e., a service-based reimbursement policy. Under such a system, fees would be set for services rendered regardless of the provider and only this amount would be reimbursed by third party payers. Thus, both the NHP and the physician could maximize the use of their skills to the greatest benefit of the patient while effectively containing costs. References are included.

3. Weiner, Stephen M. "'Reasonable Cost' Reimbursement for Inpatient Hospital Services Under Medicare and Medicaid -- The Emergence of Public Control." American Journal of Law and Medicine, 3/1 (1977), 1-47.

The emergence of public control over reasonable cost reimbursement policies for inpatient hospital services provided under the Medicare and Medicaid programs is described. In 1965, Congress established the Medicare and Medicaid programs, mandating that participating hospitals be reimbursed for the reasonable cost of providing inpatient services. The charge made is that DHEW, being anxious to stimulate the voluntary participation of hospitals in the programs, interpreted reasonable cost with excessive liberality toward participating hospitals and thus created a fiscally burdensome and inflationary reimbursement system lacking principles of efficiency and planning. There has been a series of attempts since then to reformulate the concept of reasonable cost, as applied to Medicare and Medicaid reimbursement, in a manner more consistent with sound public policy and financial constraints. The culmination of these attempts was P.L. 92-603 (Social Security Amendments of 1972) which introduced to the reimbursement system the concepts of: stringent evaluation of the reasonableness of hospital costs, with emphasis on efficiency, utilization, and planning; shifting de facto power over reimbursement rates away from the hospitals and into the hands of the agencies that purchase their services; and increased public scrutiny of hospital operations. It is concluded that this law represents a healthy balancing of the needs of hospitals and the needs of the public and that the trend toward cost control and public control which the law embodies has been substantially furthered in States with statutorily established hospital budget or charge review programs. It is predicted that the trend toward cost control and public accountability will continue and will affect any proposed national health insurance plan.

4. Blumberg, Mark S., and Gentry, Douglas W. "Routine Hospital Charges and Intensity of Care: A Cross-Section Analysis of Fifty States." Inquiry, 15/1 (1978): 58-73.

A major determinant of average hospital cost per patient day is the volume of services received per day. The weighted volume of services that patients receive is what is meant by the intensity of care. The study was based on data from calendar year 1972 obtained from hospitals in all 50 States. The study was initiated in response to the publication in May 1975 of the reimbursement of hospital charges by the Medicare program. Based on that schedule, hospitals were reimbursed by the average cost of patients per day. Cost per patient day, however, is not always a good criterion to use for actual cost. Five factors affect the cost incurred by a patient: disease, patient status (general health), medical and nursing practices, length of stay, and hospital admission rate. It was generally found that hospitals with a lower than average length of patient stay exceeded the per day limitations imposed by Medicare. This is because, regardless of the length of stay, some services need to be performed by the staff on the patient. A shorter length of stay means only that the services must be performed within a shorter time span, not that the services need not be performed at all. Conversely, a 10 percent increase in the length of

stay will lower the cost per day by 4 percent. It was also noticed that hospitals with a disproportionately high RN staff have higher costs per patient day. Present efforts to limit per diem costs, therefore, are not compatible with concurrent efforts to reduce length of stay. The analysis was performed using multiple regression. Several tables show the correlations of the variables used.

5. New Jersey State Commission of Investigation. Report of the New Jersey State Commission of Investigation (S. C. I.) on Hospital Phase of the Medicaid Program. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

The report is the sixth prepared by the New Jersey State Commission of Investigation as part of its evaluation and probe of the entire Medicaid program in New Jersey, as requested by Governor Brendan T. Byrne. Prior reports covered nursing homes, independent clinical laboratories and professional practitioners receiving program funds. This report concerns the in-patient hospital phase of the Medicaid program and the adequacy of fiscal controls developed by the State to insure efficiency, economy and integrity. The commission found in the course of its investigation that the New Jersey Medicaid program began in January 1970 at the mid-point of an unprecedented hospital cost increase spiral.

6. Head, James L. "Regulatory Environment for Physician Compensation." Topics in Health Care Financing, 4/3 (1978): 75-90.

Governmental regulation of physicians' fees is coming to the attention of legislators, physicians and the public as the effort of health care cost containment increases. It has become obvious that controls placed on hospitals are not sufficient to contain costs, as a significant portion of the increase in health care costs is composed of professional fees. In addition, any regulation must take into account that health and quality of care are the goals of any worthwhile health care practice or program. The article reviews current Federal regulations for physician fees under the Medicare, Medicaid, uniform cost reporting and Professional Standards Review Organization programs as well as a number of current State regulations. Proposed legislation currently being studied in Congress is analyzed as well as consumer attitudes toward physician compensation legislation. As a result of these trends and attitudes, the article concludes that there is a need for action on the part of physicians to prepare for a mandated rate review and reimbursement system and a movement away from lease and percentage-type arrangements, especially for hospital based physicians. Incentive systems aimed at improving quality, increasing productivity and containing costs will also largely become the responsibility of physicians in managing their departments' costs. References and suggested readings are included.

7. Longmire, Warren T.; Derzon, Robert A.; and Wickware, Dana. "Health Care Priority One -- Cost Containment. Interview Transcript. Patient Care, 15 (1978).

This is an interview with Robert A. Derzon, former Administrator of the Health Care Financing Administration (HCFA), a new agency created in DHEW in the spring of 1977. HCFA is responsible for administering Medicare and Medicaid and for the Professional Standards Review Organization (PSRO) network. Cost control without impairing the quality of care is an overriding goal. This used to mean ferreting out fraud in tax-supported programs. It now means containment of care costs. Mr. Derzon believes that cost containmen' lies with physicians, because costs spring directly from decisions the' 'e. He believes that cost containment policies can be followed in physicia care choices without undermining care quality, and that they have a critical function in care delivery. The interview also covers such topics as national health insurance, the level of government involvement in health care, the role of physician extenders, the success of PSRO's, realistic cutbacks in the number of hospital beds and redundant facilities, and physician reimbursement.

8. Gulley, Charles Douglas. Analysis of the Effects of the Medicare and Medicaid Programs on the Cost of Hospital Services: A Case Study. Doctoral Dissertation. Ann Arbor, Michigan: University Microfilms International, 1976.

The University of Arkansas Medical Science Campus Hospital in Little Rock is the subject of this case study to determine whether Medicare and Medicaid actually cause inflation. The development of health legislation, concepts, proposals, and actions leading to the Medicare and Medicaid programs is traced. A descriptive analysis of data collected from the hospital's administration, finance, and accounting departments and from the medical records library is presented. General hospital statistics and data concerning hospital assets, expenses, and revenues are included. Ancillary services, diagnostic and therapeutic services performed by specific hospital departments, and routine patient care, such as room and board, are analyzed for their potential effect on costs. It is concluded that Medicare and Medicaid were the major causes of inflation above the general rate of inflation in this hospital. The average length of stay was increased by Medicare patients, thus increasing costs. The downward trend of the occupancy rate of the hospital indicated that excess beds might exist, causing increased costs. Nursing service costs increased from slightly over $1 million in 1967 to $1.4 million in 1974. They were $11.25 in 1967 and $15.91 in 1974 per patient day, reflecting a 41.4 percent increase. Ancillary service data did not support the charge of over-utilization. Increases in the costs of food, drugs, and supplies were significant. Supporting tabular data are appended, and a selected bibliography is provided.

9. Holahan, John, et al. Altering Medicaid Provider Reimbursement Methods. Washington, DC: The Urban Institute, 1977.

Alternative Medicaid reimbursement strategies for physicians, hospitals, long term care facilities, and health maintenance organizations (HMO's) are explored. Existing systems for reimbursing physicians are analyzed, and emphasis is placed on the administrative difficulties of implementing alternative systems and on incentive effects generated by them. Options and implications of controlling costs under alternative

systems are discussed. Customary and prevailing charge reimbursement and fee schedules are noted as the two main physician reimbursement systems used by State Medicaid programs. Alternative options available to States include placing limits on the rate of increase of reasonable charge screens, defining prevailing charges as a lower percentile than the 75th, failing to update physician profiles, and freezing fee schedules. Problems encountered in the payment of hospitals are considered. Several potentially attractive cost control options are suggested: uniform fee schedule, variable fee schedule, inclusive rate setting, fixed budget for all hospitals, and cost-based reimbursement. Issues in the payment of long term care facilities are investigated. It is argued that alternative reimbursement systems can be logically divided into those which relate payment rates to the costs of a specific facility and those where reimbursement levels are independent of the costs of a facility. Medicaid policy with respect to HMO's is analyzed. The primary concern in HMO reimbursement is that the rate does not exceed the fee-for-service experience.

10. Deane, Robert T., and Matthews, Peter F. Analysis of Incentive Reimbursement System for Health Care and LTC Services Provided to the Elderly and Long Term Disabled. Final Report. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

The report presents the development and simulation of an incentive reimbursement formula. The formula was developed using analysis of covariance. The dependent variable was private pay patient charges in an effort to avoid the cost-pass-alongs associated with traditional accounting cost-based systems. A key dependent variable was patient debility. Its inclusion not only explained a great deal of the variations in costs, but will ensure equitable treatment of all patients regardless of debility level. The formula was estimated using the 1973 National Nursing Home Survey data and was simulated in Minnesota and North Carolina. Results showed that total Medicaid costs would remain essentially the same, but the distribution of reimbursements among facilities would be altered.

11. Ashby, John L., Jr., et al. Report on Systems of Reimbursement for Long Term Care (LTC) Services. Volume II: Proceedings of Conferences. Final Rept., Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

Contents: Introduction and summary of regional conferences; National Conference on LTC Reimbursement; certificate of need vs. financial incentives to achieve an optimum supply and distribution of facilities; cost reporting and auditing requirements for skilled nursing and intermediate care facilities; public utility regulations and the nursing homes -- we know the answer, what's the question; the Utah long term care payments system; nursing home reimbursement -- property investment; returns to equity capital in nursing homes; Title XIX reimbursement in long term care.

12. Reiss, John B. "Proposal for the Future Scheme of Payments to Certain Health Care Institutions." Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1978.

A scheme of payments to certain health care delivery institutions, i.e., a cost-based incentive revenue budget based on patient case mix, developed in New Jersey under a contract from the Health Care Financing Administration, is outlined for long term planning purposes (1983 to 1988). The system is intended to minimize regulation by rewarding hospital response to public policy positions on cost containment and resource reallocation and is structured to emphasize planning goals for the total system. In considering financial elements, the definition of these elements, prospective or retrospective payment, and units of account (payment by case, per diem, a la carte, by a fixed revenue budget, and capitation plans), as well as differences in third-party payers, especially types of benefits and extent of coverage are discussed. The payment scheme involves choosing between financial alternatives to achieve a desirable mix of incentives and gradually phasing in the system. The discussion of cost allocation covers outpatient and inpatient services, a model payment scheme for direct patient care services, cost incentives, institutional services, and issues in capital cost payments. The rate setting program developed by the New Jersey Department for Medicaid patients illustrates application of the scheme to long term care facilities. A State budget review agency must establish performance standards for health care institutions by considering quality determination of Professional Standards Review Organizations. Major unresolved policy issues are formulation of an outpatient care payment system, consideration of differential benefit effects and benefit coverage of various payers, and political problems of changing resource allocation. An appendix listing pertinent New Jersey Health Department publications, two diagrams, and one table are furnished.

13. Comptroller General of the United States. History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control these Costs: 1966 - 1975. Washington, DC: General Accounting Office, 1976.

Cost increases incurred in the Medicare and Medicaid programs between 1966 and 1975 are examined. Information on DHEW's implementation of the Medicare and Medicaid cost control provisions of the 1967 and 1972 amendments to the Social Security Act is provided. Administrative actions taken by DHEW to control program costs are examined. Reasons for the increased program costs of Medicare and Medicaid are cited. Two primary reasons are inflation and an increase in the number of persons eligible for Medicaid benefits. Cost control efforts in both programs are reviewed. Consideration is given to Congressional and DHEW efforts and to experimental and demonstration projects in cost control sponsored by DHEW. These projects are concerned with hospital prospective reimbursement, long term care reimbursement, and incentive reimbursement. Further Congressional efforts to control Medicare and Medicaid costs are recommended. Suggested legislative actions include the purchase of durable medical equipment and Medicare claims processing contracts. Appendixes contain additional information on Medicare and Medicaid costs and their control.

14. Davis, Karen. "Medicaid Payments and Utilization of Medical Services by the Poor." Inquiry, 13/2 (1976): 122-135.

Trends in Medicaid expenditure are examined, and the impact of Medicaid on the utilization of medical services by the poor is assessed. Medicaid costs are said to be high not because people receive too much care or because the government pays exorbitant rates for care, but because (1) there are 23 million people receiving Medicaid services each year, up from 9 million in 1967; (2) medical care costs are generally high; and (3) Medicaid meets the health care costs of many elderly and disabled persons confined to nursing homes. While trends in patterns of medical care utilization and health status under Medicaid have been encouraging, there are major qualifications to that progress, including the following: (1) differences in use of physician services are not adjusted for the generally greater health needs of the poor; (2) progress in utilization has not been shared by all of the poor and has not been accompanied by a movement of the poor into 'mainstream medicine'; (3) there are important disparities for particularly disadvantaged groups, such as the rural poor or minorities; and (4) Medicaid has been less successful in reducing the financial burden of medical expenditures for all poor persons. Gains in access to medical care achieved by the poor under Medicaid are examined, and implications of the Medicaid experience for health policy are noted. It is pointed out that Medicaid costs are perhaps too controllable, leading to interference with the goal of providing medical care to all persons regardless of ability to pay. A second conclusion is that any major role for States may interfere with ensuring access to medical care for all. Supporting data are included.

15. Davis, Karen. "Achievements and Problems of Medicaid." Public Health Reports, 91/4 (1976): 309-316.

A critical review is offered of the accomplishments and shortcomings of Medicaid from its inception through mid-1976. Four basic problem areas are identified: rising costs; gaps in coverage of the poor and needy; limits on benefits and limited participation in the program by mainstream medicine (i.e., private health facilities, physicians, and other health professionals); and the inequitable distribution of benefits by State, urban - rural residence, and race. It is suggested that Medicaid costs are high not because recipients get too much care or because the government pays exorbitant rates for that care, but because: (1) the number of people receiving Medicaid services has increased from 9 million in 1967 to over 23 million in 1976; (2) medical care costs in the United States are generally high, regardless of whether the patient is covered by Medicaid; and (3) Medicaid has assumed the responsibility for meeting the health care costs of many elderly and disabled persons confined to nursing homes. It is noted that, to place any significant restraints on future Medicaid costs, these underlying causes must be addressed. Utilization data are cited as evidence that Medicaid has had considerable success in meeting its original objectives of insuring adequate medical care for covered persons and reducing the financial burden of medical expenditures for those with severely limited financial resources. However, several qualifications about that progress are made, primarily concerning the inequitable distribution of Medicaid

benefits, i.e., the failure of the program to treat people in equal circumstances equally. Several alternatives for introducing reforms in the four problem areas are noted: (1) maintaining the present program, with State governments continuing to exercise their current authority to expand or restrict eligibility, benefits, and other aspects of the program; (2) maintaining the present program, with State governments' broader authority to use Medicaid funds for health services for the poor; (3) providing for tighter cost control through Federal actions; (4) providing for Federalization of the Medicaid program, with uniform coverage of all poor persons and comprehensive benefits; (5) integrating the financing of health care for the poor into the financing of health services for all Americans through national health insurance; or (6) reassessing the existing financing - service delivery mix and using financing mechanisms to promote development of health services delivery. Supporting statistics are included.

16. Sorensen, A. A., and Saward, E. W. "An Alternate Approach to Hospital Cost Control: the Rochester Project." Public Health Reports, 93/4 (1978): 311-317.

The rapid escalation in health care costs has demonstrated a need to control costs in general and hospital costs in particular. In New York State, efforts at control have followed one of several paths, including reduction of Medicaid program expenditures, elimination of hospital beds, and prospective reimbursement of hospital costs. Although some success has been achieved in each of these areas, hospital cost containment has not been as successful as had been hoped. A new project called MAXICAP, being developed in the Rochester region, seeks to link payment with regional hospital planning. MAXICAP represents a voluntary attempt by hospitals, third party payers, planners, consumers, and governmental agencies to devise a prospective hospital payment system. Under this system community hospital plans in the Rochester region would be integrated and a cap imposed on both revenues and expenses for acute hospital care. The principal advantage of the MAXICAP is that it offers a mechanism for linking hospital planning with payment functions on a regional basis. The principal disadvantage is that the success of the MAXICAP depends upon the voluntary cooperation of the vast majority of the acute care hospitals in the area -- hospitals that may be scattered throughout a relatively large region.

SECTION X

Fraud and Abuse

1. U.S., Congress, House Committee on Ways and Means, Subcommittee on Health; Committee on Interstate and Foreign Commerce, Health and Environment Subcommittee; Library of Congress, Congressional Research Service. Fraud and Abuse in the Medicare and Medicaid Programs. Washington, DC: Government Printing Office, Superintendent of Documents, 1977.

Provider fraud and abuse associated with the provision of health services financed by Medicare and Medicaid are explored. Disclosures of fraud and abuse in shared health facilities, clinical laboratories, nursing homes, prepaid health plans (health maintenance organizations), independent practitioner offices, and pharmacies are detailed. The most common violations in shared health facilities are referring patients from one practitioner to another without a medical reason for doing so, billing for multiple services to a relative who accompanied a family member who sought treatment, billing for a service more extensive than that actually provided, directing a patient to a particular pharmacy, and either adding services not performed on an invoice carrying legitimate billings or submitting a totally fraudulent claim. In clinical laboratories, fraudulent practices include charging for services not ordered by a physician, charging for questionable tests, charging Medicaid patients more than private patients, billing patients for component parts of automated laboratory tests, and the use of forms supplied by the laboratory which encourage overutilization. Most nursing home violations pertain to financial transactions and improper reporting of days of care. Fraud in prepaid health plans deals with fee schedules, payments, and enrollment. There is much less evidence of fraud and abuse among independent practitioners than in the other settings. Fraud and abuse control activities of DHEW are detailed.

2. Pies, H. E. "Control of Fraud and Abuse in Medicare and Medicaid." American Journal of Law and Medicine, 3/3 (1977): 323-332.

This comment explores issues concerning the control of fraud and abuse in health programs financed with public funds, specifically the Medicare and Medicaid programs. It summarizes the nature, scope, and possible causes of what some regard as a fraud and abuse "crisis," and points out the difficulties and obstacles facing those who attempt to develop legislative and executive action aimed at controlling fraud and abuse. Recent Federal initiatives in fraud and abuse control are examined, and a brief summary of key provisions of H.R. 3 (the Medicare-Medicaid Anti-fraud and Abuse Amendments, which may prove to be a landmark piece of legislation in this area) is provided. The author emphasizes that more effective control of fraud and abuse is necessary if further expansion of government financing of health programs, including national health insurance, is to occur in the near future. At the same time, caution must be taken not to neglect the appropriate use of other mechanisms necessary for reducing the costs of medical care and improving its quality. In addition, it is likely that efforts to stem fraud and abuse will raise important medicolegal and public policy issues that will require careful interdisciplinary consideration.

SECTION XI

Provider Issues

PHYSICIANS:

1. Bogue, Ted. Why Not the Most: A Physician's Guide to Locating Cities with the Most Excessive Medicare Fees in the Country and an HEW Guide to Stopping this Waste of a Billion Dollars. Springfield, VA: Dept. of Commerce, National Technical Information Service, 1977.

The results of a study of geographic variations in Medicare prevailing physician charges are presented, and recommendations for reform in the Medicare physician reimbursement system are offered. Data on maximum physician fees paid by Medicare carriers in the 25 largest metropolitan areas for 4 frequently performed procedures (cholecystectomy, repair of inquinal hernia, prostatectomy, and extraction of lens) are analyzed. It is argued that the geographical differences in the charges are indefensible. The study indicates that they did not reflect variations in cost of living, malpractice premiums, other professional expenses, quality of care, or demand and supply. The real reason for the differences is said to be that the payment system permits physicians in local reimbursement areas to substantially determine their own charges. A consequence of a lack of constraints has been rapid fee inflation. One of the suggested reforms is that DHEW be given authority to substitute a national Medicare fee schedule for the 'reasonable charge' system. This fee schedule would be based on the lowest Medicare fees being paid. Adjustments would be made for inflation and for actual geographic variations in cost of living, as well as variations in professional expenses.

2. Rudolf, Ronald J. Physician Care and Government Programs: An Analysis of the Distribution of Health and Health Services in New York City and the Nation. Doctoral Thesis. Ann Arbor, MI: University Microfilms, 1976.

The distribution of physician care and the effectiveness of various government programs in providing care to the poor and indigent in New York City and the United States as a whole are analyzed. Data were obtained from the New York City population health survey and from the health interview survey of the National Center for Health Statistics and covered the years 1964, 1965, 1966, 1968, and 1969. The distribution of mean physician visits was compared prior to and after the enactment of Medicaid and Medicare. A demand for physician visits was estimated in relation to certain socioeconomic variables. Comparisons before and after Medicaid and Medicare showed that the distribution of mean physician visits in New York City was U-shaped with respect to family income. The large number of municipal and voluntary hospitals in New York City was considered to be responsible for the U-shaped distribution. Demand equations relating physician visits to the severity of illness and other variables revealed a gap between the care received by the poor and the wealthy in New York City in 1969. This gap increased with the severity of illness. On a national basis, the number of physician visits per capita declined slightly between 1964 and 1969, in spite of an increase in insurance coverages. Appendixes contain supporting data, information on the analysis procedures, and the population health survey form. A bibliography is provided.

3. Sloan, Frank; Cromwell, Jerry; and Mitchell, Janet B. A Study of Administrative Costs in Physicians' Offices and Medicaid Participation. Final Report. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

Contents: Survey methodology; effects of incentives on physician performance; organization of practice mode; administrative costs in physician's practice; a conceptual framework for analysis of physician payment-in-full programs; policies and procedures of third-party reimbursement; Medicaid participation; reduced fees and bad debts of physicians; direct payment by third party payers to physicians

4. Garner, Dewey D.; Liao, Winston C.; and Sharpe, Thomas R. Participation Effect on Medicaid Utilization. Final Report. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

The object of the study is to determine what factors affect physician behavior with respect to acceptance and rejection of Medicaid patients. The first phase includes a descriptive analysis (using the entire population of 1,777 Mississippi physicians) of demographic characteristics as determinants of participation in Medicaid programs. The second phase includes a telephone survey that assesses the attitudes and behavior of a stratified random sample regarding their participation in Medicaid programs. Survey study population consists of 1,521 medical practitioners who provide direct patient care from an office-based practice. Approximately 350 physicians were interviewed (175 participants and 175 non-participants) in relation to characteristics of the practice, their attitudes, and behavior when confronted with Medicaid eligible patients. The major reasons given for physicians not participating in Medicaid program are: the reimbursement is too low, requires excessive paper work, patient abuse of program, dislike of government's involvement, and too expensive to the taxpayer.

5. Sloan, F.; Mitchell J., and Cromwell, J.. "Physician Participation in State Medicaid Programs." Journal of Human Resources, 13 (1978), Suppl. 211-245.

Medicaid requires that physicians who accept Medicaid reimbursement for treating a patient agree to accept its payment as payment in full. Policy instruments under Medicaid's control are both levels of reimbursement and various administrative burdens imposed on physicians by the program. A model depicting the physician's participation decision is developed, and predictions from the comparative statistics analysis are discussed. Data came from a 1975-76 survey of fee-for-service physicians. The results indicate that high fee schedules and low administrative burdens are ways to stimulate physician involvement with Medicaid patients. Results on the Medicaid policy instruments and other explanatory variables on the whole lend support to the model of physician behavior proposed earlier in the paper.

6. Thacker, S. B., et al. "Primary Health Care in an Academic Medical Center." American Journal of Public Health, 68/8 (1978): 771-773.

In 1975-76 a one-year longitudinal study of the delivery of primary care services was carried out at all ambulatory institutional facilities in

Durham County, North Carolina, and in 47 of 50 community private practices covering the broad fields of surgery (including urology and orthopedics), medicine, pediatrics, and ob/gyn. The present paper focuses on the private and public clinics of Duke University Medical Center. Data were analyzed to document differentials in sociodemographic characteristics of patients attending these two systems of care. Results showed that patients attending the private clinics are predominantly white and covered by private insurance, while patients attending the public clinics are predominantly black and heavily dependent on Medicaid coverage. The potentially detrimental effects of a two-class system of care on the health of patients, as well as on the education of students, is discussed in the context of a scant medical literature on this subject.

7. Burney, I. L., et al. "Geographic Variation in Physicans' Fees: Payments to Physicians under Medicare and Medicaid." JAMA, 240/13 (1978): 1368-1371.

To study georgraphic differences in physician fees recognized by the Medicare and Medicaid programs, the authors analyzed physician reimbursement rates at the national, State, and county levels. The results indicate that nationally, Medicaid specialist fees in metropolitan areas are 23% higher than those in nonmetropolitan areas, but there are no differences under Medicaid. State Medicare specialist fees varied from 73% to 132% of the national Medicare average, while Medicaid specialist fees ranged from 49% to 179% of the national Medicaid average. State Medicaid fees for specialists ranged from 39% to 100% of Medicare specialist fees. These results indicate that under national health insurance, fees set at national or Statewide levels could have notable effects on physician remuneration in some localities.

8. Perlman, B. B., et al. "Medicaid-funded Private Psychiatric Care in New York City: The Role of Foreign-Trained Physicians." New England Journal of Medicine, 299/5 (1978): 230-234.

Data were obtained from the tax records and the Professional Registry maintained by the New York City Department of Health as well as from the Biographical Directory of the American Psychiatric Association to determine which psychiatrists were providing care under the Medicaid program and how they compare with the pool of psychiatric practitioners in New York City. The data reveal that psychiatrists educated in foreign medical schools provide disproportionately more care to Medicaid recipients than would be anticipated from their numbers, and are a majority of those who received more than $30,000 in payments in 1976. Furthermore, these psychiatrists account for 80 percent of those delivering care at the two largest "shared health facilities," commonly referred to as "Medicaid mills." These findings indicate that although the Title XIX program has facilitated the access of the poor to the private psychiatric sector, in New York City their access is biased toward treatment by foreign-educated psychiatrists.

9. Egbert, L. D., and Rothman, I. L. "Relation Between the Race and Economic Status of Patients and Who Performs Their Surgery." New England Journal of Medicine, 297/2 (1977), 90-91.

The authors evaluated the relation between race and economic status of surgical patients and their likelihood of being treated by a surgeon in training rather than by a staff surgeon. Blacks were 2.2 to 4.3 times more likely than whites to be under the care of surgeons in training (P less than 0.001). This relation has remained unchanged over the past two decades. It remained when the method of payment was via self-payment or private insurance, but disappeared when patients being paid for by Medicaid were considered. In addition, black emergency patients were more likely than white emergency patients to be cared for by surgeons in training.

DENTISTS:

1. Nebraska State Dept. of Public Welfare. Dental Handbook. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

This manual provides supporting documentation for the evaluation of the Medicaid Management Information System of the Nebraska Department of Public Welfare. A dental handbook containing information concerning the Nebraska Department of Public Welfare Medicaid Dental Care Program is presented. Provider agreement is discussed, and a sample application and agreement is included. Other subjects discussed include: medical care standards; dental services; prior authorization; services rendered outside Nebraska; freedom of choice and documentation of services; approval, maximum fees, and payment in full; and procedures and codes. A sample prior authorization document is included, and instructions for completing the Nebraska Department of Public Welfare claim form are given. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) system is discussed, and instructions are provided for completing the EPSDT claim form. Claim adjustments are examined, and an appendix containing dentist license numbers is provided.

2. Fazio, R. C. and Boffa, J. "A Study of 'Broken Appointment' Patients in a Children's Hospital Dental Clinic." Journal of Dental Research, 56/9 (1977): 1071-1076.

Part I of this study investigated possible variables determining "High Risk No Show" behavior on the part of the patients in a dental clinic. Only "source of payment" seemed important; namely, that Medicaid patients were statistically more likely to be "High Risk No Show" patients (P less than .001). Race was associated but was found to be confounded with Medicaid. In an attempt to investigate the reasons for the Medicaid group being "High Risk No Show" patients, Part II of the study compared three distinct groups of patients at the Children's Hospital Medical Center Clinic. These included the self-paying group and the Medicaid group of the original sample of 90 in addition to the Union plan group (patients receiving free third-party care as an employee benefit). It was shown that both groups with third-party coverage were associated with "High

Risk No Show" behavior. The type of "No Show" behavior, however, was different for the two groups. Union plan patients tended to cancel appointments or at least notify in advance of inability to keep an appointment. Medicaid patients, conversely were just as likely to miss appointments and not file advance notice of inability to keep an appointment.

PHARMACISTS AND DRUGS:

1. Johnson, Norman C., et al. Iowa Title XIX Experimental Capitation Program for Pharmaceutical Services. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

This project was designed to modify one component of the Medicaid program in Iowa, the drug program, in an attempt to improve efficiency. Background information on inadequacies of the Medicaid drug program is presented. These inadequacies concern professional fees, reimbursement, administrative problems, consumer aspects, and financing. In 1972, it became apparent that the Iowa Medicaid drug program needed to be modified in order to enhance its efficiency and quality. The experimental project incorporated capitation reimbursement, as well as other techniques, and involved a contractual relationship between the Iowa State Department of Social Services and pharmacies in two counties responsible for the provision of drug services to Medicaid patients. The aspects of the project which are examined include the roles and responsibilities of patients, pharmacists, physicians, the Iowa State Department of Social Services, and Blue Cross of Iowa, and evaluation (the drug use process, services, consumer acceptance, and pharmacy costs and acceptance). The project findings are not detailed in the report, although the potential value of the project is discussed in relation to national health insurance.

2. Knapp, Deanne E., et al. "Low Cost, Manual Drug Use Review of Medicaid Recipients to Screen Prescriber and Pharmacist Performance." American Hospital Pharmacy, 35 (1978): 437-440.

A pilot test for an economical drug use review (DUR) program that could be used to screen outpatient prescribing in large third-party programs, such as Medicaid, was carried out. The aim was development of DUR methodology for programs unable to afford computerized DUR. A Medicaid drugs data base was used with 100 patients over a 3-month test period. Screening criteria developed for the test dealt with drugs of choice, daily dose and refill patterns, therapy length, drug holidays, and disease-drug and drug-drug interactions. The results showed that only 11 percent of the tested population had prescribing patterns that passed all screens. The most common problem was found to be prescription of drugs not considered drugs of choice. It was felt that in most of the cases which did not pass the other screens, a pharmacist with patient records should have been able to detect the problems. After a cost analysis the implementation of a manual DUR program would be approximately $1,053 plus $530 for subsequent quarterly review. Thus, a manual DUR can effectively screen prescribing procedures and detect prescribing problems for large third-party programs.

3. Sudovar, Stephen G., and Rein, Susan D. Managing Medicaid Drug Expenditures: An Analysis of Divergent Approaches. New York, NY: Ben Kubasik, 1978.

Approaches to managing Medicaid drug expenditures were analyzed to test the assumption that more stringent government regulations and/or controls over pricing and availability of drugs would lead to a reduction of total drug program expenditures, and to make a contribution to the application of data analysis to policy decisions in Medicaid drug programs. The study includes factors such as the relationship of the recipient/eligible participation rate to comparative State cost data, the weighting of aid category distribution, and the effect of controls on administrative costs. It also presents analytical methodologies that are newly applied to Medicaid comparative analysis. The two State Medicaid programs selected for analysis (California and Texas) differ markedly in administration of the drug services component. The Texas program is characterized by administrative mechanisms for management of the drug component: a prescription limit per recipient per month and an automated utilization management system for both provider and patient activity. Payment to providers is also limited, and claims processing and all review activity are handled in-house. The Medi-Cal program features continuing efforts to introduce additional new control procedures, including cost containment. Data processing and claims payments are performed out-of-agency. Analysis of the data from the two States showed the effect of participation rate and other factors on derived cost services and overall expenditures. The report concludes that efficient utilization management and efficient administration of drug programs are the most cost-efficient factors under the control of Medicaid managers. The appendixes contain information on data adjustment methodology and hypothetical savings.

4. Vlasses, Peter H., et al. "Drug Therapy Review in a Skilled Nursing Facility: An Innovative Approach." Journal of the American Pharmaceutical Association, 17/2 (1977): 92-94.

Medicare and Medicaid programs require a pharmacist to develop, coordinate, and supervise all pharmaceutical services in skilled nursing facilities. In Wilmington, Del., the community pharmacist, feeling limited in his ability to review and monitor drug therapy in the several nursing homes he serviced, contracted the services of a clinical pharmacist consultant to perform the monthly drug therapy review. The Episcopal Church Home was chosen by the consultant pharmacist as a pilot review study for one year. The pharmacist's communications were entered on the drug therapy communication sheet on each patient's chart. An analysis of the results of the communications showed that 71 percent of the communications were answered directly by the physicians. The clinical pharmacist's communications were in the following categories: drug-related problems, disease management considerations, administrative problems, and educational considerations. The majority of the recommendations were in the disease management category and consisted of the following: duplicate medication, unwarranted medications, inadequate treatment, appropriate monitoring, and unidentified problems. A table shows that the physicians accepted some of the recommendations, but others were not instituted. A further study needs to be made to review the significance of the recommendations which were accepted by the physicians, and those which were not.

5. Brocklebank, J. C., et al. "Drug Prescribing During Pregnancy. A Controlled Study of Tennessee Medicaid Recipients." American Journal of Obstetrics and Gynecology, 132/3 (1978): 235-244.

The effect of pregnancy on prescribing was assessed in a population of pregnant Medicaid recipients and two matched groups of control women. Of the 2,528 gravidas, 62 percent received systemic legend drugs (excluding dietary supplements) during their pregnancies. White women and women 30 years of age and older were most likely to receive these medications. Systemic anti-infectives were the most frequently prescribed category of drugs (excluding dietary supplements). One fourth of the women received a narcotic-containing drug and 13 percent of the women received psychotropic drugs, most frequently diazepam. Barbiturates and narcotic-containing drugs were often "hidden" in a fixed combination medication. In general, prescribing did not decrease as a result of pregnancy. This study and other studies reviewed here emphasize the need for comprehensive drug-use guidelines for physicians who care for pregnant women.

THERAPISTS:

1. American Occupational Therapy Association. "Occupational Therapy." American Health Care Association Journal, 4/3 (1978): 12-18.

Occupational therapy's role in nursing home care is discussed. The areas in which the occupational therapist can provide services to nursing home residents include treatment, maintenance, and activities. The therapist can also serve as a member of the health care provider team. The treatment program uses activities to correct physical or psychological disabilities. The maintenance program, on the other hand, is intended for residents who have reached their optimal level of functioning and require activities to help them retain their abilities. Activity programs are intended to help prevent premature deterioration of mental, social, and physical abilities, as well as to maintain lifestyle. A physician may refer a nursing home resident for occupational therapy to allow the resident to overcome the effects of disabling conditions through the use of assistance devices, clothing adaptations, and instructions in self-help techniques. Another reason for referral might be to correct or reduce disability through the use of activities which are intended to increase joint motion, muscle strength, and coordination. The three roles of the occupational therapist in the nursing home facility include consulting (e.g., helping the administrator to formulate written policies for providing occupational therapy services, and participating in the inservice education program); serving as supervisor of the occupational therapy program; and providing treatment. Case studies are used to illustrate each of these roles. The discussion concludes with an outline of the services which are reimbursable under Medicare. A sample agreement for occupational therapy services accompanies the text.

RURAL HEALTH:

1. Davis, Elizabeth. "Funding Rural Nurse Practitioner Care." Nursing Outlook, 25/10 (1977): 628-629.

The Visiting Nurse Association of Burlington, Vt., established a health care program for Grand Isle County, a group of islands that has about 3,750 residents, many of whom are farmers. An initial survey showed that 77 percent of the preschoolers had no source of regular preventive health care. A mobile unit utilizing a pediatric nurse practitioner to provide pediatric screening services was operated 3 months a year as an initial attempt to reach this population. Volunteers were used to help run the clinic and to publicize the service. Two years later, after a survey of resident interest in the service and of types of needs, an adult screening unit program, and care for the episodic illness for adults as well as children, were made available in a stationary unit. The staff was expanded to include a paramedic, volunteer receptionists, and the pediatric nurse practitioner, who with additional education, provides the adult services. Consumers are responsible for setting the policy for the center. Physician backup service is provided through telephone consultations and periodic on-site visits, and there are established linkages with specialty services and the medical center serving the area. Individual patient and family records are organized in the problem-oriented format in order to facilitate planning, implementing, and evaluating systems of health care as well as individual patient care. The service operated on grants and patient fees for the first two years. However, Blue Shield has now agreed to reimburse the center for the nurse practitioner services received by their policy holders under a pilot project proposal, and the State Medicaid system may soon provide a similar reimbursement program.

2. Rockoff, Maxime L. "Technology in Rural Health Care." Commitment, 2/4 (1977): 24-29.

Advanced technology can solve some problems of rural health care delivery. Mobile units have the following advantages in offering part-time clinic services to small populations widely dispersed around a central community: (1) services are brought to patients who lack transportation; (2) no fixed facility need be available; (3) multiple sites and duplicated material are unnecessary; (4) high visibility; (5) a community's needs can be gauged before investment in permanent facilities; (6) construction approval is unnecessary; (7) ease of leasing arrangements; and (8) potential resale value. Space Technology Applied to Rural Papago Advanced Health Care (STARPAHC) is the most sophisticated unit. Mobile units have certain inherent disadvantages as well. These include: (1) high operating and maintenance expenses; (2) loss of time in transit; (3) wearisome travel for the staff; (4) poor maneuverability; (5) crowding of patients; (6) poor privacy; (7) excess noise; and (8) lack of 24 hour availability. A fixed facility staffed part time solves some problems, and minimally trained aides using telecommunications (telephone, radio, satellite, television) can staff such a facility 24 hours. Expensive two-way television is not a practical alternative, but telephone lines which transmit images and physiological signals are being explored. However, telephone communication is still expensive, inconvenient, and of poor quality in very remote areas. A long distance telephone call may cost the physician more than his Medicaid reimbursement. An automated medical records system, which does billing for physicians and pharmacies, as well as allowing professionals to discuss cases, is being used in rural South Carolina. It improves records and communications between medical staff but can sacrifice privacy and require structured input.

SECTION XII

State Issues and Programs

1. Alaska Legislative Affairs Agency. Division of Research. Opting: A Study of Medicaid Client Need. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1977.

Contents: overview of the Medicaid program; current status of the Medicaid program in Alaska; general information regarding Medicaid optional services; Medicaid client needs; analysis of other States' experience with selected options; conclusions to the study; glossary of terms.

2. Connecticut General Assembly. Program Review and Investigations Committee. Containing Medicaid Costs in Connecticut. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

The legislative program review and investigations committee issued a 'preliminary review of selected Medicaid issues in Connecticut,' in March 1976. The preliminary report made some two dozen important recommendations, many of which have already been implemented. The purpose of this report is to provide an in-depth analysis of the State's Medicaid program, to identify problems and to recommend solutions designed to improve performance and reduce the rate of growth in program costs. Medicaid expenditures in Connecticut have been increasing at an average annual rate of more than 15% since FY 1971, and are expected to exceed $200 million in FY 1977. The scope of the study included four main types of cost controls -- eligibility controls, price controls, utilization controls, and expenditure controls.

3. New Jersey State Commission of Investigation. Report of the New Jersey State Commission of Investigation on the Practices and Procedures of Practitioner Groups Participating in the New Jersey Medicaid Program. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

As part of its evaluative probe of the entire Medicaid program in New Jersey, the State Commission of Investigation (S.C.I.) assigned one of three investigative teams to look into the area of health services encompassing providers of other than nursing home and hospital care. Among the major components of this section of the program are dentists and physicians practicing in groups or otherwise associated by virtue of sharing space at a common facility. The practitioner phase of the investigation focused upon the workings of individual medical facilities devoting at least 75% of their practice to Medicaid and bringing in substantial amounts of Medicaid money and the manner in which these facilities are administered by the New Jersey Division of Medical Assistance and Health Services (DMAHS). Findings and recommendations are reported.

4. Ellwood, Paul M., Jr. A Resource Paper for Decision-Makers: 'Health Care Issues of Importance to Minnesota'. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

The purpose of the report is to provide information on political issues in health that are important to Minnesota. The report is presented in three sections. The first section places Minnesota health issues in a meaningful framework by considering the reasoning behind the National

Health Maintenance Plan. The second suggests approaches that States may take with respect to Federal programs such as Medicare and Medicaid. Finally, matters of concern to States that do not involve Federal programs directly are discussed.

5. Cannon, Joseph E. "Third-Party Coverage in Rhode Island." Rhode Island Department of Health Newsletter, (June 1977): 1-14.

Statistics on enrollment and expenditures by health insurers in Rhode Island are presented, as available, for the 1940's, 1950's, 1960's, and 1970's. In 1976, approximately 85 percent of the State's population was enrolled in Blue Cross/Blue Shield. Included in the 1976 Blue Cross enrollment of 783,883 were 19,679 members of the Rhode Island Group Health Association and 35,420 enrollees in the Federal Employees Program. In 1974, 196,000 Rhode Islanders were covered by policies issued by commercial health insurance carriers. Of these 158,000 had group policies and 38,000 had individual policies. In 1976, 22,622 Rhode Islanders were members of health maintenance organizations. From 1975 to 1976, total expenditures by third parties increased from $363,464,000 to $435,606,000, a gain of 19.8 percent. The three leading payers -- Blue Cross/Blue Shield, Medicare, and Medicaid -- accounted for 77.4 percent of third-party payments in 1972 and 80.9 percent in 1976. From 1972 to 1976, per capita expenditures by third parties in Rhode Island rose from $243.15 to $472.22, an increase of 94.2 percent. A 1975 health interview survey showed that 5.5 percent of Rhode Islanders had no health payment coverage. Lower socioeconomic groups, the unemployed, and young adults were least likely to have coverage. Tabular data are provided.

6. Wisconsin Department of Health and Social Services, and Wisconsin Office of the Lieutenant Governor. Management Improvement Fund Proposal: Demonstration of PERC System in Two Regions of Wisconsin. Springfield, VA: U.S. Dept. of Commerce, National Technical Information Service, 1976.

A method is described for improving the management of nursing home patient evaluation in Wisconsin. Evaluation is accomplished through the patient evaluation review committee (PERC) plan to assess patient needs, assign staffing patterns appropriate for needs, and reimburse in a manner consistent with staffing patterns. The PERC plan was formulated in 1973 in an attempt to correct deficiencies in the nursing homes of Wisconsin. Two tools were developed to assist in the implementation of PERC: (1) areas of care evaluation (ACE) and (2) time unit base (TUB) system. The ACE form permits evaluators to categorize patients according to their total needs. The TUB system correlates the patient profile with services appropriate for a particular patient. ACE was tested in 40 homes with 3,136 patients, and activity data were collected from a subsample of 18 homes with 1,259 patients. Nineteen patient profiles were prepared. The PERC plan is shown to be an effective method for identifying specific areas of patient need, for determining appropriate staffing criteria, and for providing a means by which the Medicaid program can reimburse for specific service hours needed rather than reimbursing on a blanket coverage basis for services determined by negotiation. Wisconsin's Department of Health and Social

Services plans to implement the PERC system in two regions of the State. Funding requirements for the system's implementation are presented in tabular form.

7. Fulchiero, A., S., et al. "Can the PSRO's be Cost Effective? A Study of the Effect of the Commonwealth Health Agencies Monitoring Program on the Length of Stay of Medicaid Patients in Massachusetts." New England Journal of Medicine, 299/11 (1978): 574-580.

To analyze the effect of the Commonwealth Health Agencies Monitoring Program on the length of stay of a sample of Massachusetts Medicaid patients, the authors compared their experience with that of non-Medicaid patients. They found a consistently decreasing trend in the length of stay of Medicaid patients during the 2 1/2 year period studied. The average length of stay of Medicaid patients decreased by 11.9 percent relative to the norm, whereas the non-Medicaid length of stay decreased by only 6.6 percent. The authors infer that the program may be credited within the 5.3 percent differential decrease. The consistency and reliability of the data suggest that similar results may be extrapolated to the hospitals not sampled. The authors conclude that Professional Standards Review Organizations, of which this program was a precursor, can be cost effective, given an expanded review mandate and the application of suitable evaluative processes.

8. Fuller, N. A.; Patera, M. W.; and K. Koziol. "Medicaid Utilization of Services in a Prepaid Group Practice Health Plan." Medical Care, 15/9 (1977): 705-737.

To provide medical service at lower costs without diminishing either quality or coverage, the District of Columbia enrolled approximately 1,000 Medicaid beneficiaries, voluntarily, in a prepaid group practice (PGP). The project was evaluated over a three-year period (1971-1974) with regard to: 1) rate of utilization of medical care before and after enrollment; 2) costs of care per capita as compared with those of the 160,000 beneficiaries in the Medicaid fee-for-service universe; and 3) patient satisfaction with the PGP. Results indicate that for the 834 individuals aged 1 through 64 enrolled in the PGP: ambulatory physician encounter rates decreased 15 percent, drug utilization was down 18 percent, hospital admissions decreased 30 percent, and hospital days declined 32 percent after enrollment. For the same benefit package, annual prepaid per capita costs for the Medicaid PGP enrollees for 1972, 1973, 1974 were only $282, $232, and $286 respectively, representing a 37 percent saving when compared to the fee-for-service per capita costs of the Medicaid universe which were $373, $435 and $465 over the same period. The instrument used to probe patient satisfaction showed the study group was satisfied with the PGP, and received better dental care. The voluntary dropout rate from the PGP was only 2.5 percent; and out-of-plan utilization was low, indicating good acceptance of the PGP service.

9. Lamb, H. R., and V. Goertzel. The Long Term Patient in the Era of Community Treatment." Archives of General Psychiatry, 34/6 (1977): 679-682.

Post hospital follow-up studies do not encompass the total population of long term, psychiatrically disabled patients in the community,

because a large proportion (in this study, 64%) have not had a recent hospitalization, either State or local. The authors identified a population of long term, psychiatrically disabled patients in the community, all of whom carried functional psychotic diagnoses. Long term disabled patients generally lead inactive lives, but in California seldom return to State hospitals. One third have been hospitalized locally within the past two years - younger patients much more than older patients. Almost half use private (Medicaid) outpatient services, but one fourth receive no mental health services at all. Less than a third live in board and care homes or cheap hotels; most live in nonsegregated, noninstitutional settings. The role of Supplemental Security Income (SSI) in enhancing adaptation of the chronically disabled was impressive to the research team.

Appendix

Developmental Review in the EPSDT Program
A synthesis of material supplied by various position papers, conference proceedings and helpful suggestions. Rather than the use of a single instrument, the report recommends that each review must include multiple assessment procedures tied to the age of the child and the dimensions to be assessed. 49pp. HCFA-77-24537

EPSDT in Action: Positive Program Practices - Program Administration and Management - South Carolina
A first attempt to provide technical assistance to States in an effort to publicize positive program practices wherever they are found. This issue provides the overall program administration and management operations for South Carolina. 7p. SRS-76-24518

EPSDT Needs Physicians and Dentists
An effort to briefly explain the program and its merits and thereby enhance provider participation. 6p. SRS-76-24104

EPSDT: Overview 20 pp. HCFA-77-24524
EPSDT: History 20 pp. HCFA-77-24525
EPSDT: Organization 15 pp. HCFA-77-24526
EPSDT: Clients 11 pp. HCFA-77-24527
EPSDT: Child Health 71 pp. HCFA-77-24528
EPSDT: Service Tasks 57 pp. HCFA-77-24529
Orientation to EPSDT: Trainer Instructions
Training Guide A 142 pp. HCFA-78-24530
Problem Solving in EPSDT: Trainee Workbook
Training Guide B 25 pp. HCFA-77-24533
Orientation to EPSDT: Trainee Workbook
Training Guide A 22 pp. HCFA-77-24531
Problem Solving in EPSDT: Trainer Instructions
Training Guide B 84 pp. HCFA-78-24532

The above listings are components of a package designated as EPSDT training materials. They represent a collaborative effort of the University of Michigan's School of Public Health and School of Social Work. The information is especially geared to paraprofessionals and allied health personnel.

A Guide to Administration, Diagnosis and Treatment: EPSDT
A report designed to be of help to those initiating and managing the complexities of an effective EPSDT program. 76pp. HCFA-77-24534

A Guide to Dental Care: EPSDT - Medicaid
An effort to assist those who will be primarily involved in implementing the dental care component of EPSDT. 86pp. SRS-74-24515

A Guide to Screening: EPSDT - Medicaid
A manual written to help public officials, physicians, nurses and others to plan and carry out an effective EPSDT program. It focuses on screening activities and their relationships to the other components of the program. 205pp. SRS-74-24516

Health Screening and Treatment for Children
A colorful, attractive pamphlet designed for the potential target population in an effort to briefly explain the merits of the EPSDT program. 6pp. SRS-75-24921 (rev.)

EPSDT: The Possible Dream
An attempt to explain the magnitude of the EPSDT program and the scope of its activities which make it a major experience in the process of developing a national preventive and comprehensive health care system. 28pp. HCFA-77-24973

Why EPSDT?
A pamphlet aimed at administrators and consumers. It briefly, but expertly, explains EPSDT's historical significance, Congressional mandate and implications for the program. 4pp. SRS-77-02049

Medicaid: EPSDT for Individuals Under 21: Guidelines
This material provides guidelines on the regulation (now superseded) pertaining to the requirement for early health care for young Medicaid recipients. 23pp. SRS-72-24321

Marketing EPSDT to Clients: A Self Instructional Module for EPSDT
(Self-explanatory) 71pp. SRS-75-24353

Marketing EPSDT to Clients: A Self Instructional Module for EPSDT Trainer's Guide
(Self-explanatory) 15pp. SRS-75-24354

A Report on Professional Health Provider Participation - EPSDT - Medicaid
Details of the problems of implementation of EPSDT as identified by national professional provider organizations in a national symposium. It also reports on the recommendations made by the participants. 25pp. SRS-75-24517

Recipes for Success - Head Start and EPSDT
This manual was developed as a result of a two-year demonstration collaborative effort between Head Start and Health/Welfare agencies. The purpose of the manual is to assist Head Start programs in making maximum use of the EPSDT program. 172pp. OHD-76-31097

EPSDT --- A How-To Guide for Head Start Programs

This manual was developed in response to Head Start staff in their use of EPSDT services for Medicaid-eligible enrolled Head Start children. It is a companion to Recipes for Success - Head Start and EPSDT. 50pp. OHDS-78-31119

Federal Programs that Relate to Children - 1979

This report identifies the general nature and scope of on-going U.S. Federal government activities in 1979 that affect children. It does not intend to provide complete information on all government agencies that have programs which affect children. Rather, this compilation exemplifies the effort of cooperation among agencies.

*U.S. GOVERNMENT PRINTING OFFICE : 1980 0-620-233/4308

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